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THEY'VE GOT THE WRONG END OF THE STICK

Put them right about the benefits of Flixonase Allergy Nasal Spray, all year round. Tell them there's no better way to relieve the symptoms of all major airborne allergies; from animal dander to house dust mites to mould spores, as well as pollen. Let them know that by spraying just once a day, they can treat all their symptoms from itchy eyes to groggy heads. And they should be pleased to hear that, because of the way it works, Flixonase Allergy beats once-a-day antihistamines on nasal problems like congestion and that groggy blocked-up feeling.[1-6] So recommend Flixonase Allergy, because nothing is more effective without prescription.

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Flixonase Allergy Nasal Spray Product Information. Presentation: Aqueous nasal spray suspension containing 50 micrograms of fluticasone propionate per spray. **Uses:** Prevention and treatment of allergic rhinitis. **Dosage and administration:** Intranasal use only. *Adults and the healthy elderly:* Two sprays into each nostril once a day, preferably in the morning. Use twice daily if required. Do not use more than 4 sprays a day in each nostril. Prophylaxis of allergic rhinitis requires treatment before contact with allergen. *Children under 18 years:* Not to be used. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** If symptoms have not improved after 7 days or, if symptoms have improved but are not adequately controlled, consult a doctor. Not to be used for more than 3 months continuously without consulting a doctor. Consult a doctor before use in: concomitant use of other corticosteroid products, nasal/sinus infection, recent nasal injury/surgery, nasal ulceration. Risk of adrenal suppression with higher than recommended doses. Significant interactions between fluticasone propionate and potent inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and protease inhibitors, such as ritonavir, may occur. This may result in increased systemic exposure to fluticasone propionate. **Side effects:** Dryness and irritation of the nose and throat, unpleasant taste and smell, headache and epistaxis. Hypersensitivity reactions including skin rash and oedema of the face or tongue. Rarely anaphylaxis/anaphylactic reactions and bronchospasm. Extremely rarely nasal ulceration and nasal septal perforation usually following previous nasal surgery. **Pregnancy and lactation:** Do not use except with medical advice. **Legal category:** P. **Product licence number:** PL 10949/0360. **Product licence holder:** Allen & Hanburys, Stockley Park, Middlesex, UB11 1BT. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex, TW8 9GS. **Package quantity and RSP:** 60 spray pack £6.79. **Date of preparation:** December 2002. **Flixonase** is a registered trade mark of the GlaxoSmithKline group of companies.

References: 1. Ratner PH *et al.* J Fam Prac 1998; **47:** 118-125. **2.** Stricker WE *et al.* Ann Allergy Asthma Immunol 1998; **80:** 115. **3.** Kaszuba SM *et al.* Arch Intern Med 2001; **161:** 2581-2587. **4.** Jordana G *et al.* JACI 1996; **97:** 588-595. **5.** Gehanno P and Desfougeres J-L. Allergy 1997; **52:** 445-450. **6.** Vervloet D, Charpin D, Desfougeres JL. Clin Drug Invest 1997; **13(6):** 291-298.

GlaxoSmithKline Consumer Healthcare

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This week

Regulars

Pharmacy update

Features

'Direct supervision' to go in new Health Bill

by Ailsa Colquhoun/Asha Fowells

Registered and suitably trained staff working in the pharmacy could soon be able to supervise the supply of medicines without being overseen by a pharmacist.

The Health Bill published on October 27 proposes to replace the requirements for a pharmacist to be in personal control with a 'responsible pharmacist', charged with the safe and effective running of the business.

This would allow for legislation enabling designated staff to undertake pharmacy activities while the responsible pharmacist is absent, provided safe operating procedures are employed. The Bill does not, however, outline the conditions necessary for supervision to be deemed to be in place.

Each pharmacy will also have to have its own responsible pharmacist, and the Bill proposes that regulations should set out the duties and activities involved. Duties would include making a record of the responsible pharmacist on any day and at any time. Failure to do so will be a criminal offence, carrying a fine of up to £1,000.

Responsible pharmacists will be able to supervise relevant activities at another pharmacy, but pharmacists who have qualified in an EU state and whose qualification is recognised in the UK will not be allowed to be the responsible pharmacist in premises registered for under three years.

A chapter on pharmaceutical services proposes to allow PCTs in England and LHBs in Wales to charge for applications to their pharmaceutical lists, and to take account of proposals relating to the sale or support of over the counter medicines and healthcare products, but only when there are competing applications.

A chapter on Controlled Drugs also aims to provide the legislative base for the programme in response to the fourth Shipman Inquiry. All NHS healthcare organisations, including PCTs, will need to appoint an accountable officer and to ensure that the organisation and any providers have robust arrangements in place for the safe and effective handling of CDs.

Measures to counter fraud include strengthening the penalties with a maximum two-year prison sentence and a fine for persons found guilty of misleading a fraud investigation.

Contracts linked to OTCs

The Department of Health has backed the idea that applications to provide NHS pharmacy services should be linked to improvements in access to, and provision of, over the counter medicines and advice.

In a partial regulatory impact and competition assessment, the DoH says that the OTC medicines link will enable differentiation between competing applications and would result in better quality of services and prices. It accepts that there is a "marginal but unquantifiable risk to smaller businesses" and says that pharmacies may conclude that they need to provide a wider range of medicines at lower prices. It adds that charging fees of £150-£500 for determining applications would save the NHS £450,000 and would help deter speculative or 'blocking' applications.

David Reissner, head of healthcare at Charles Russell Solicitors, thought the proposals would be difficult to implement. "An applicant can hardly undertake to sell all medicines or specific medicines more cheaply than competitors," he said. And if the DoH intends PCOs to consider OTC sales only in the case of applications from someone not already in the pharmaceutical list, this would discriminate against multiples. "The DoH will probably have to look at this again," he said.

NPA chief executive John D'Arcy, pictured, agreed: "We shall object strongly to contracts being granted on the basis of OTC medicines prices. If it is one of a range of factors being considered, it is a way of differentiating between applications, but we are still concerned these applications may not be judged on their breadth of pharmacy services being offered."

Pharmacy responds

Despite describing the new Health Bill as a "highly significant piece of legislation that will have long-lasting impact on the future of the pharmacy profession", the Royal Pharmaceutical Society has expressed disappointment that the Bill does not set out any details of the proposed changes to supervision. Noting that these will now have to be written into the pharmacy regulations at a later date, the Society says that these will need detailed consideration if they are to deliver the changes that the profession seeks while maintaining patient safety.

What the legal experts say

Contractors can only speculate on what remote supervision will entail, said David Reissner, right, of Charles Russell Solicitors, suggesting that supervision via the telephone or delegated supervision to a registered technician may be an option.

Legislation will also have to be written to cover the qualifications and experience a pharmacist in charge must have. Using time on the Register of Chemists as a criterion "could cause difficulties for those relying on newly qualified pharmacists to manage their pharmacies (or, indeed, for newly qualified pharmacists who want to own their own pharmacies), in view of the current shortage of pharmacists". New legislation may also include rules to stipulate how long the responsible pharmacist can be absent from a pharmacy and what can or cannot be done in his or her absence.

Highlighting the notion of the 'responsible pharmacist', Mr Reissner said: "This may represent an important shift in responsibility in the case of pharmacies owned by companies.

"Until now, the RPSGB has tried to hold the superintendent pharmacist responsible for anything that goes on at pharmacy premises. Any breach of the new duty will not be an offence: the DoH intends that enforcement will be down to the RPSGB or PCTs."

The Bill at a glance

Part one: provisions to make enclosed public places and workplaces in England and Wales smoke-free.

Part two: provisions relating to healthcare associated infections (in England and Wales only).

Part three: the use of Controlled Drugs in the UK; and amendments to the current regulations relating to pharmacist supervision.

Part four (for England and Wales only): proposals to levy charges on applications to provide NHS pharmaceutical services; general ophthalmic services; NHS counter fraud powers; provision for the auditing of NHS bodies' accounts.

Part five: will set up an Appointments Commission for UK public bodies.

Part six: legislative changes to various Acts including the *Care Standards Act 2000* and the *National Health Service and Community Care Act 1990.*

Part seven: general matters, including provisions relating to orders and regulations..

RPSGB

First code of conduct case clears ex-Council member

by Anna Hodgekiss

A former member of the RPSGB's Council has expressed concerns over the treatment he received from colleagues after facing a disciplinary hearing.

Despite being cleared of the charges, he says there was a 'whispering campaign' against him. He also claims that the new Council is still being subjected to similar behaviour, which is undermining the profession.

Noel Wicks was speaking after the outcome of the first code of conduct hearing for the Society's Council was published this week. Two complaints were made to the panel in November 2004. The first allegation concerned his authorship of an advertisement feature in *C&D* in October 2004. This included his Council membership, breaching the Council's code of conduct.

But the panel found in Mr Wicks's favour after it was established his name had been added after he submitted the draft. A PR for the advertiser said she had made the change because other authors in the series of adverts had listed their affiliations.

Although he received a proof copy of the advert, Mr Wicks failed to notice the change because he was more concerned with its actual content. The hearing said it could not be proved that Mr Wicks had noticed the change.

He was also cleared of the second allegation, that his membership of another title's advisory panel was not registered on the list of member's interests. The panel concluded that while this was true, Mr Wicks had referred to "occasional consultancy", which was similar to the standard of entry for other Council members.

Mr Wicks said after the hearing: "Although I knew I was not guilty of any offences whatsoever, I had to suffer the humiliating experience of being ostracised by Council members.

"Moreover, the whisper campaign that ensued had the effect of calling my reputation into question, even though the allegations made against me were merely allegations."

The Stirling-based pharmacist also suggested that 'Save Our Society' Council members are continuing to experience such behaviour, which was "nothing more than revenge" by those who opposed the SOS group.

Mr Wicks had the support of the Pharmacists' Defence Association. Its director, John Murphy, said the case showed a worrying trend "where a referral to the formal disciplinary process may be used as a type of punishment. Even if the complaints are groundless, once received the RPSGB is duty bound to investigate and this can be a lengthy and harrowing process for the pharmacist involved," he added.

A spokesman for the RPSGB said it would not comment.

Inbrief

NAWP event

A meeting outlining the history of the National Association of Women Pharmacists is being held on November 16.

Open to all, the event will take place at the Royal Pharmaceutical Society's Lambeth headquarters. Refreshments will be served from 5:30pm and the talk, delivered by NAWP executive member Sue Symonds, will start at 6:30pm.

Cardiff date

Pharmacy buying group Cambrian Alliance is encouraging independent pharmacists to visit its annual trade show in Cardiff this November.

The event takes place on November 16 at the Vale Hotel in the Welsh capital.

For more information:

e-mail: *jeangwynne@cambrianalliance.co.uk*

Bald move for Boots

Halting hair loss will be the next target for Boots following the launch of its weight loss programme.

The retailer is offering male pattern baldness treatment Propecia (finasteride) as part of a trial scheme at a store in Manchester.

A successful response among patients could see the scheme roll out to other UK stores in 2006.

NPA election

Nominations for election for Area 15 of the NPA Board need to be with the NPA by noon on November 23. Voting papers will be distributed on December 2, and need to be returned to the NPA by noon on December 20.

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in October:

- Acne (1351)
- Antiseptics (1352)
- Vet health part 3 (1353).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on *www.dotpharmacy.com*. Further information is available from Mary Prebble on 01733 377269. Genus Pharmaceuticals supports the MCQ and telephone marking service.

PRACTICE

NHS boosts safety for pharmacies under attack

by Max Gosney

NHS chiefs have pledged extra security support for pharmacy staff after a study on violence against primary care workers found the profession suffered the worst attacks.

Pharmacists fell victim to "the most serious" incidents including armed robbery and assault, found an NHS Security Management Service (NHS SMS) report. The study aimed to test the reporting of violence against healthcare staff at PCT areas including Hillingdon, Dorset, Liverpool and North Kirklees.

Pharmacists will receive enhanced legal backup and could enrol on security training courses following the trial, the NHS SMS said at an event held at the Royal College of General Practitioners in London this week.

The organisation, in conjunction with other health stakeholders including the Pharmaceutical Services Negotiating Committee, said it had launched *The Way Forward Working Together* scheme to tackle abuse against NHS staff.

Pharmacists coming forward with cases could expect enhanced support, said Alex Nagle, director of NHS security management at NHS SMS. "The most important resource to the NHS is its staff and we aim to ensure those people are properly protected. We will ensure every report is dealt with in a suitable and effective way."

The NHS SMS response will include appropriate legal action against an assailant should a police or Crown Prosecution case fail, according to the organisation.

Extending NHS security services to pharmacy was a significant step for the profession, said Alastair Buxton, head of the PSNC's NHS services. "I think there's an issue about pharmacy feeling part of the NHS family and this scheme is evidence that we are a valued component. The system is in place to protect us but pharmacists must report when an incident happens."

However, the scheme would need to see a major attitude change among pharmacists in order to succeed, warned Adli

Tadros, pharmacist at Anthony Tate Pharmacy in Victoria, London. He said: "I've been attacked twice with a knife in the pharmacy and reported it to the police but not the PCT. I just don't see whether they can offer any practical help."

MEDICINES

Pharmacy is first choice for EHC

Pharmacies have become the most popular source of emergency hormonal contraception (EHC).

According to a report published by the Office of National Statistics, 50 per cent of women obtained EHC from a pharmacy in 2004/05 – a 23 per cent increase from the previous year. The proportion accessing EHC from a GP or walk-in centre fell from 41 per cent to a third, and from 11 per cent to 3 per cent respectively between 2003/04 and 2004/05. Just over a fifth of women continued to get EHC from a family planning clinic.

Overall, there was no change in the 7 per cent of women aged 16 to 49 who reported using EHC.

Royal Pharmaceutical Society practice and quality improvement director David Pruce said: "The numbers of women obtaining EHC from a pharmacy without prescription marks a quiet revolution in access to this type of contraception, with women now much more aware that they can get safe and effective treatment from their local pharmacy."

But Conservative MP David Amess is launching a campaign to have EHC reclassified as a Prescription Only Medicine. He said he was "horrified" to discover that 618 prescriptions for the product were written in his constituency during 2004/05. **AF**

Inbrief

Red Boots

Boots has launched into the Russian pharmacy market.

The retailer has teamed up with Russian health and beauty firm 36.6 to distribute its own-brand range including Botanics and No7 to 40 Moscow stores.

If successful the scheme could roll out to 400 stores across Russia, confirmed Boots.

24-hour trading

Superdrug will offer round the clock opening at its store in London's Oxford Street this Christmas. The extended hours will be operated from December 19 to 23, announced Superdrug.

Fraud awareness

Scotland has declared November to be NHS fraud awareness month in hospitals, following an anti-fraud campaign in pharmacies earlier this year.

Counter fraud services staff will tour around Scottish NHS boards and hospitals, highlighting the impact fraud has on the NHS and improving knowledge about how it can be reported.

GP insight

IT supplier Cegedim UK has launched a new service which will provide information on GP prescribing habits.

The criterion practice level aims to assist pharmaceutical companies looking to target healthcare workers for sales and marketing campaigns, according to Cegedim UK.

ETP rollout

IT supplier Positive Solutions has backed its Analyst ETP system to begin full deployment to pharmacies this month.

Martin Jones, commercial manager for Positive Solutions, predicted the Analyst system would quickly meet NHS Connecting for Health (CfH) ETP testing criteria.

"We are delighted to report that our system has raced through testing in record time with very few hitches and that Analyst ETP will be ready for full deployment from November," he said.

The Analyst system is currently in trials at the Prestwich Pharmacy in Manchester.

Boots does IT

Boots has completed the rollout of its pharmacy IT system to stores.

The QicSCRIPT PMR system, supplied by System Solutions, can be configured to offer electronic prescription services in the future, stated Boots.

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When your customers are ready to quit smoking, they need more than just the NRT you sell.

By recommending ***NiQuitin CQ®*** *Clear 24-hour patch, you'll be offering them round the clock craving protection, along with the opportunity to get clinically proven behavioural support from the* ***Click2Quit®*** *Stop Smoking Plan.*[1]

Customers can visit ***Click2Quit.com*** *for their personal quit plan.*

Quit with NiQuitin

NiQuitin CQ 21, 14, 7mg Transdermal Patches, NiQuitin CQ Clear 21, 14, 7mg (nicotine) opaque or transparent transdermal patches 21 mg, 14 mg, 7 mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. Dosage stop smoking completely. *>10 cigarettes/day;* Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks *<10 cigarettes/day;* Step 2 for 6 weeks then Step 3 for 2 weeks. Complete full course. Max 10 consecutive weeks. Apply to fresh site (clean, dry skin) once daily. **Contraindications:** non/occasional smokers, children under 12. Recent MI/ stroke, severe arrhythmia, unstable/worsening/ resting angina. Hypersensitivity. **Precautions:** adolescents 12-17 years, cardiovascular disease including uncontrolled hypertension; severe renal /hepatic impairment, peptic ulcer, hyperthyroidism, insulin-dependent diabetes, phaeochromocytoma, dermatitis. Concomitant medication may need dose adjustment. **Side effects:** Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness. Depression, irritability, anxiety, nervousness, restlessness, mood lability, drowsiness, impaired concentration, insomnia, sleep disturbance. Allergic reactions, abnormal dreams, nausea, vomiting, dry mouth, GI disturbance, headache, dizziness, palpitations, tachycardia, tremor, dyspnoea, pharyngitis, cough, arthralgia, myalgia, sweating, chest pain, fatigue, malaise, flu-like symptoms. **Pregnancy/lactation:** try without nicotine replacement therapy. Medical assessment of risk/benefit if necessary. **GSL.** PL 00079/0347, 0346, 0345, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS. **Pack size and RSP:** All strengths 7 patches £17.49, Step 1 only 14 patches £32.95. **Date of revision:** March 2004

Reference: 1. Strecher V *et al.* Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-6 August, 2003.

FINANCE

Boots stays calm over plunging profits

by Max Gosney

Boots chiefs remain confident of future success despite the retailer recording a £17 million profit slump during 2005.

Chief executive at the company Richard Baker said Boots had made strong progression even though interim results showed a 1.3 per cent fall in like for like sales to September 30, 2005.

"The last six months have been a period of further significant progress for Boots as despite a weak consumer environment, we have continued to invest in our infrastructure, our operations and our customer offer," he commented.

Boots group trading profits declined 9.6 per cent to £163m from March to September 2005. Operating costs increased by £45m as the retailer invested in its "building a better Boots" programme, added Mr Baker.

Boots's health division registered a solid performance with a 0.6 per cent sales rise.

Dispensing volumes increased by 5.1 per cent but profits were hit by the revised Pharmaceutical Price Regulation Scheme and price reduction on generic medicines, according to Boots.

The retailer reported a 1 per cent rise in OTC sales, with the new contract having a "neutral" effect on Boots's pharmacy profits.

A Boots spokesman commented: "Pharmacy has become a core part of our business. Boots's health business has made a good profit in a difficult market."

Boots's overall decline in profits explained the rationale behind the company's decision to merge with Alliance-UniChem (AU), suggested city experts.

Hilary Cook, director of investment strategy at Barclays Stockbrokers said: "The results show that Boots is struggling to live with supermarket giants who've entered the healthcare market. You can see why they needed AU. The company is having to operate on lower margins. But I think it's got the cash flow to do that."

Boots results

Group trading profit: -£17m.
Group sales: + 0.8 per cent.
Like for like sales: -1.3 per cent.
Health business: +0.6 per cent.
Beauty & toiletries: +3.3 per cent.

PEOPLE

PCTs 'need to do more on pharmacy agenda'

A pharmacist has called on a Labour MP to help ensure PCTs look at the pharmacy agenda "and not let pharmacists be sidelined in GP-dominated PCTs".

Kiran Patel also told the MP, Margaret Moran, how the lack of funding at present is holding enhanced services at bay. "I impressed upon the MP that this was a vicious circle whereby if valuable GP time was to be freed up, then the PCTs had to seriously look at these enhanced services," he said.

Mr Patel, chairman of Bedfordshire LPC, had invited Margaret Moran to visit his Medigreen Pharmacy in Luton last week. The pharmacy contract was the main discussion point, with Mr Patel explaining how it dovetails with the general medical services contract.

He also told the MP that a significant amount of work was already required for essential services. And while many pharmacists had worked hard to improve their skills, independent contractors were disadvantaged in not having the back office support that the multiples took for granted.

Luton by her pharmacist Kiran Patel (photo: support for pharmacy from MP Margaret Moran)

POLICY

Charity slams partial smoking ban as unworkable

PharmacyHealthLink has condemned the Government's partial ban on smoking as unworkable and irresponsible.

Last week, health secretary Patricia Hewitt announced plans to outlaw smoking in all enclosed public and work places, except licensed premises that do not serve or prepare food and private members' clubs as part of a new, wide ranging Health Bill (*see also p4*). But the charity PHL has described the proposals for England and Wales, as "extremely disappointing", and said it showed "a shocking lack of understanding for the public health issues".

If passed, the ban will come into force in summer 2007, and there will be fixed penalties for those who light up in a place designated smoke-free. People running smoke-free premises face fines if they fail to enforce the ban.

The Bill also contains legislation on "healthcare associated infections" in England, such as MRSA, including:

- The introduction of a code of practice that sets out standards for infection control and hygiene, and to which all NHS healthcare providers must adhere.
- The Healthcare Commission will have a duty to evaluate compliance and issue improvement notices as necessary. **AF**

PRACTICE

Guild slams new pharmacist NHS pay bands

The Guild of Healthcare Pharmacists has slammed the new *Agenda for Change* NHS pay bands as confusing and misleading.

Although the majority of hospital pharmacists are yet to receive their pay bandings, GHP chair of terms and conditions David Miller says that the Guild already has concerns about the Pharmacist Entry Level (band five), which saw pre-registration graduates start in August on salaries of between £16,389 and £18,698.

Noting anecdotal evidence of other problems with pay band implementation, the GHP is to poll members for feedback at the end of this month.

The Association of Pharmacy Technicians UK (APTUK) is also to poll members after some reported receiving a band three profile, despite this being withdrawn earlier this year. APTUK reports that it has negotiated a new profile for primary and secondary care pharmacy technicians at band five, but is urging other members who have not been job-matched, or are unhappy with their previous matching outcome to appeal.

For its part, Amicus, the NHS employee trade union, says it has evidence that some NHS Trusts have misspent *Agenda for Change* implementation funds and has demanded a 'substantial' pay increase for 2006/07.

"It would be inappropriate for AfC to be unfairly implemented if this money has been allocated to other expenditure headings," the union said. **AC**

Questiontime

This week's question:
Would you be happy for medicines to be supplied from a pharmacy if the pharmacist isn't there?

- **Yes – but not Controlled Drugs**
- **Yes – if staff suitably trained**
- **No**

You have until noon on November 8 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on November 12.

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INDUSTRY

Disquiet in the ranks at Numark

by Max Gosney

Numark members have expressed misgivings over the organisation's independence after the departure of David Wood from the helm of the symbol group.

Mr Wood's exit, which followed a £30.3 million takeover of the symbol group by healthcare group Phoenix, raised issues over Numark's sovereignty, stated Ketan Patel, Numark member and proprietor of the Ethel Road Pharmacy in Leicester. He said: "David Cole (chief executive at Phoenix) assured Numark members that the organisation would remain independent from Phoenix. Yet David Wood, a former pharmacist who could reflect our interests, has been removed straight away."

Phoenix has appointed Simon Colebeck as managing director at Numark following completion of its takeover at the symbol group (*C&D, October 29, p6*).

Top-level change has fuelled insecurity among Numark members, reported Jason Baskind, Numark member and proprietor at Baskind Chemist in Leeds. "The changes make things a little bit uncertain around the organisation. Although I will remain a member, I have concerns over Numark's independence and the cost of membership fees in the future."

However, Lord Fowler, ex-chairman of Numark, called for common sense among the symbol group's members. In a letter to *C&D* he said: "Phoenix is now the new owner of the company and has the absolute right to make whatever management changes it thinks fit."

Lord Fowler also praised former chief executive Mr Wood for laying the foundations for Numark's future success under Phoenix (*see letter p15*).

Pharmaceutical wholesaler Colorama attracted 700 visitors to its inaugural trade show. The event, held at London's VIP lounge, included exhibits from Crookes Healthcare, GlaxoSmithKline and Gillette

ENGLAND

PCT boundary reforms raise fears over LPC workloads

Government plans to halve PCT numbers will make negotiations more difficult for local pharmaceutical committees, an LPC chief officer has said.

The proposals to reconfigure PCT boundaries (*C&D, August 6, p6*) appear beneficial to LPCs, as they will have to negotiate with fewer PCTs, said Hampshire and Isle of Wight chief officer Mike Holden. But in reality, the formation of localities means committees will be required to work with a larger number of bodies, and it will be difficult to ensure the right person with the right skills to do the job every time, he added.

Mr Holden's comments followed his response to a Hampshire and IOW SHA consultation on how it should restructure its PCTs. **AF**

PAGB PERSPECTIVE

It's all in the interpretation

Reading a label and understanding it are two different things, says Sheila Kelly, director of the Proprietary Association of Great Britain

"May cause drowsiness" – well of course it does, why else am I taking it? How stupid. It was the common sense feedback when a PAGB company decided to test its sleep aid leaflet with patients.

The drowsiness warning also appears in full on children's cough mixtures, where the warning to avoid driving or operating machinery might be helpful for mothers of five-year-olds prone to taking the family car out for a spin, but again looks like nonsense in terms of useful advice.

The patients' response led to a discussion about the antihistamine active ingredient, its primary use as an allergy treatment and why the warning is relevant to someone taking it for that purpose. Her eyes had glazed over long before we got to the bit where what was originally considered a side effect became the desired effect at higher doses and led to the development of over the counter sleep aids.

This warning was devised in the mid 1970s when most OTC products had not been individually assessed and were still marketed under licences of right, granted because they were on the market when licensing began. The *Labelling Regulations* and *Advertising to the Public Regulations* set out what indications could be advertised to the public and what warnings needed to be on the packs of P medicines like antihistamines and some GSL medicines such as aspirin and paracetamol.

While the advertising part of the medicines regulations has been revised the labelling part hasn't, and the development of new products like sleep aids brings the problem into focus. The trouble is that warnings devised around an ingredient alone don't always communicate well.

All pharmacists know that a key question from patients with a new medicine is "Can I drink with this?" The Plain English Campaign found 20 years ago that some people don't consider beer or wine to be alcoholic and recommended that the standard warning to avoid alcohol when driving or operating machinery should be revised.

Consumer research also shows that putting information in boxes or using capital letters reduces the communication and this part of the regulations is also out of date. These changes might have happened long ago but European rules on patient information came into force and diverted attention away from the issue.

Does it matter? Yes. When we include a statement in every advertisement to tell people to read the label and leaflet, it is important that consumers find information there that is relevant and which they can act upon. One piece of useless information may discredit the rest and perhaps it is time we addressed it. Some of the warning labels that pharmacists add to dispensed medicines could also usefully be reviewed. Over 20 years ago, the Plain English Campaign pointed out that "if symptoms persist consult your doctor", was hard for people to read, much less understand – and anyway shouldn't it say consult the pharmacist these days?

Can the regulations be changed? Yes, because they are UK specific and since all the OTC medicines are now individually licensed there is no reason why their labelling can't be controlled through the licence in the same way that the advertising is controlled. If the outcome is better information that really works, then this is a regulation we can do without.

For **FREE** POS materials ring 01484 842217

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[1] Reader's Digest 2005. [2] IRI February 2005.

SCOTLAND

Pharmacists reluctantly defend prescription levy

Representatives from the Scottish Pharmaceutical Federation have gone face to face with Scottish MPs over the issue of prescription charges.

Scottish Socialist Party MSP Colin Fox has proposed a Bill abolishing prescription charges, prior to presenting evidence to the Scottish Parliament's Health Committee.

However, in a debate scheduled to take place on BBC Radio Scotland on Wednesday, SPF chairman James Semple was to take issue with the cause. "We find ourselves reluctantly supporting prescription charges. Abolition would actually harm the health service – particularly the primary care section," he said.

Pointing out the importance of the minor ailment scheme to the new Scottish pharmacy contract, Mr Semple said that the scheme is designed to provide quicker and more convenience access to OTC medicines, and save the GP costs.

"Abolition of prescription charges would remove this 'means-testing', and render the MAS unworkable," he argued.

The SPF also rejects claims that the prescription charge deters patients from taking essential medicines and warns that its abolition would increase pharmaceutical waste. It agrees, however, that the present system is "characterised by inconsistency" and that exempt categories should be simplified. **AC**

Nottingham City Hospital is helping patients move through the care system with their medicines by giving them support medicines bags sponsored by NPA Hospital Service. The bags remind patients to take all their prescribed and over the counter medicines to their appointments. Patients are also reminded to ask for the specially printed information to place in the bag.

NPA

NPA service matches employers with pre-reg trainees

The NPA is supporting its members in the recruitment of pre-registration trainees with a free online service.

The NPA Prereg Service, which goes live from mid-November, will provide a national platform for NPA members to advertise their pre-reg vacancies.

NPA members access the facility through the NPA's secure site at *www.npanet.co.uk* and prospective pre-registration trainees register their applications through the NPA website at *www.npa.co.uk*.

The NPA will match and send details of any potential candidates via e-mail or post to potential employers. **JE**

RPSGB

Group to study CPD uptake

The Royal Pharmaceutical Society is seeking to boost the number of pharmacists and technicians using its online Continuing Professional Development resources with a new working group.

The RPSGB says that only 16,000 members have used the website to record their data.

Some have used the website, *www.uptodate.org.uk*, only once.

By establishing a new CPD working group, the RPSGB hopes to establish whether any of the arrangements for recording and monitoring CPD should be changed.

LEGISLATION

EU herbal meds directive implemented

Legislation to ensure the safety and quality of herbal medicines came into effect last weekend.

Applicable in all EU member states, the directive requires companies to submit evidence on the safety and traditional use of the product before registration is agreed. The framework will ensure all registered herbal remedies are sold with information on the product and how to use it.

Although each EU member state must have a registration scheme for herbal medicines, products legally on the market in April 2004 will be protected until April 2011. This transition period will allow companies time to register their products under the scheme, said the Medicines and Healthcare products Regulatory Agency. **AF**

PATIENTS

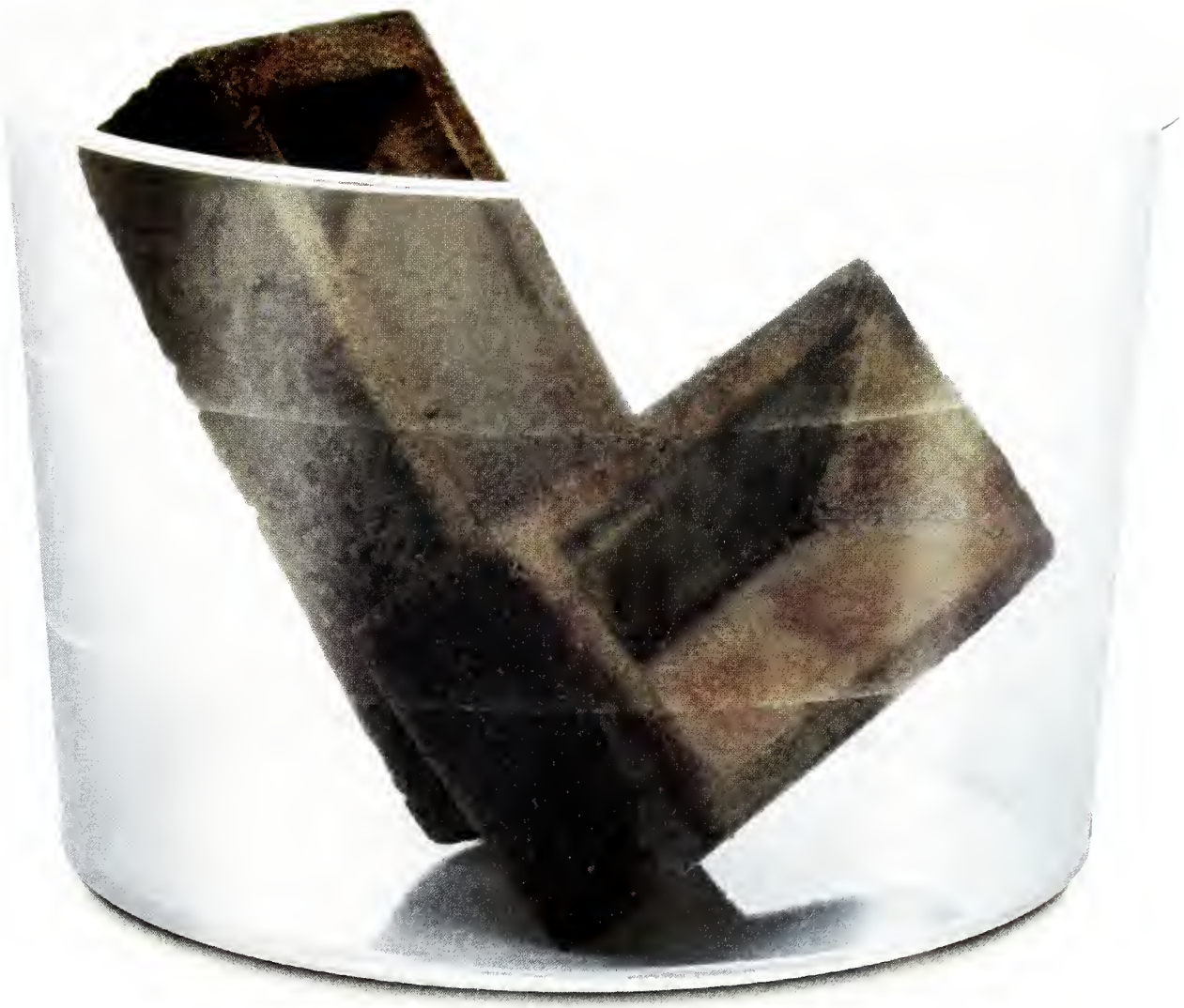
Medicines poisoning cases near 100k

Nearly 100,000 hospital admissions in 2003/04 were associated with medicines poisoning, according to a Health Protection Agency report.

Over 40,000 admissions were due to non-opioid painkillers, mainly paracetamol. Psychotropic drugs, and medicines for epilepsy and Parkinson's disease, accounted for over 18,174 and 14,684 admissions respectively. The impact of poisoning on acute hospital care has increased to just under 1 per cent of all admissions.

Problem?

Swallowing difficulties, or Dysphagia, is a widespread problem among people taking tablets. Patients and carers alike open capsules, crush tablets or mix medicine into food and drink to aid administration which can render medicine ineffective. The New Pharmacy Contract encourages pharmacists to ask patients about swallowing difficulties on a more regular basis and to supply an alternative solution. Rosemont focus on liquid solutions and offer treatment in a wide range of therapeutic areas.



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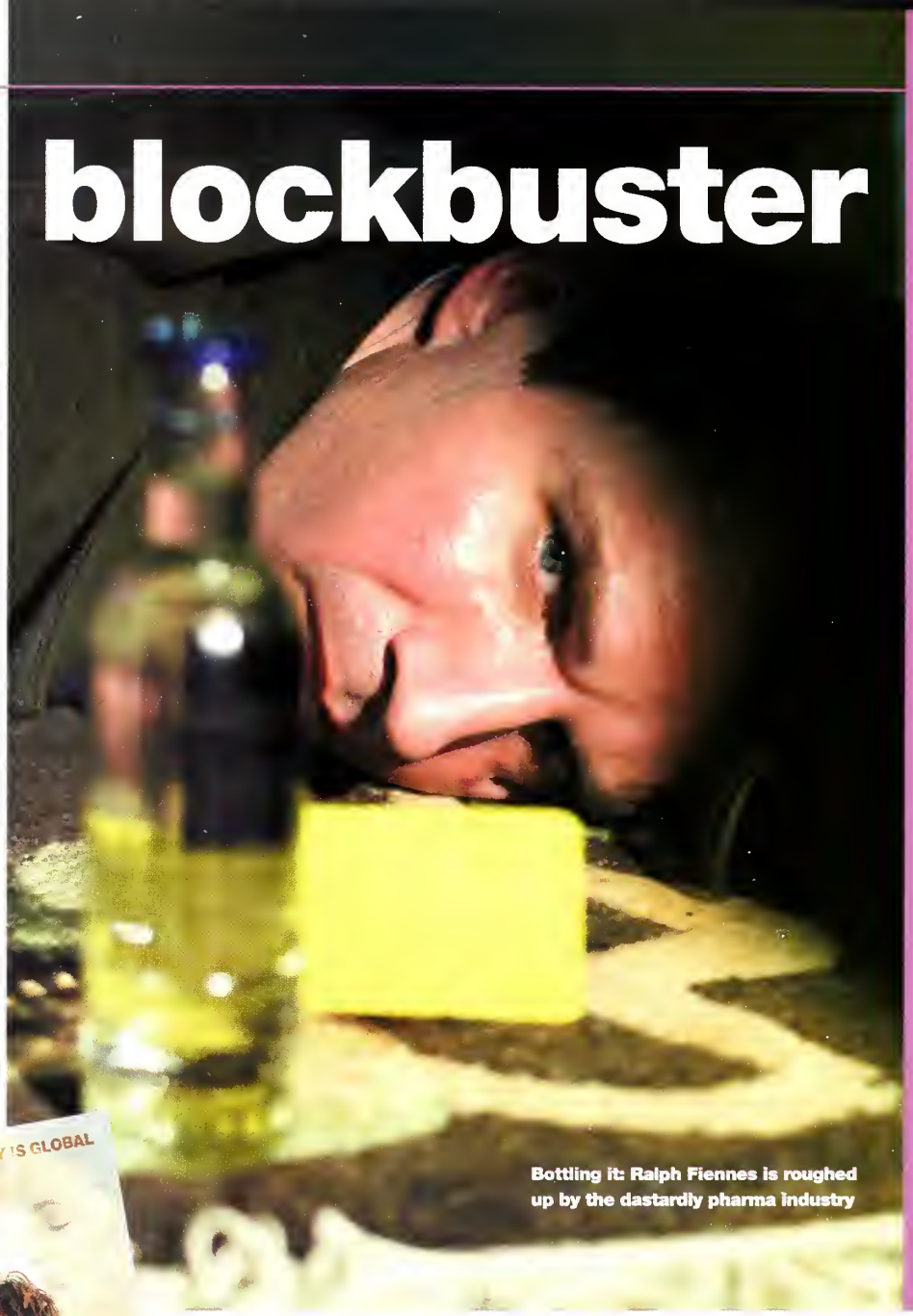
Trial by blockbuster

Big pharma goes Hollywood with the release of The Constant Gardener. Max Gosney reports on an industry in the media eye



Bottling it: Ralph Fiennes is roughed up by the dastardly pharma industry

Picture: Lions Gate

Big pharmaceutical firms are cast as the devil incarnate in the silver screen version of John Le Carré's *The Constant Gardener*.

Genocide, greed, murder and torture are all fair game as the film's fictional drug company KDH looks to cash in on a future tuberculosis (TB) outbreak by ensuring its treatment is first to market.

To speed up the process, KDH secretly tests its pipeline TB medicine Dypraxa on thousands of impoverished Kenyans as part of the country's HIV vaccination scheme.

The British government, which has been promised a UK manufacturing plant by KDH, joins the cover up when some of the human guinea pigs suffer fatal side effects from the drug.

But before the axis of evil can bank their bonuses they must fend off the efforts of the wife of a British diplomat who sniffs a scandal.

Tessa Quayle, played by Rachel Weisz, is an impassioned activist who has come to Kenya with bumbling civil servant husband Justin played by Ralph Fiennes.

She soon becomes aware of the pharmaceutical's plot while working with a local doctor and sets out to expose the scandal. However, the dastardly KDH/British government quickly dispatch Mrs Quayle, leaving a heartbroken Justin to pick up the trail.

The Constant Gardener mixes fast-paced political thriller with love story with some success. Mr Fiennes and Ms Weisz give excellent performances as the leads and are buoyed by a strong support cast including Pete Postlethwaite.

Filmed on location in Kenya, the film offers a happy/sad insight into a continent's battle against disease. *The Constant Gardener* should spark some debate over the role of blockbuster drugs in healthcare and the activities of western companies in Africa.

And with an audience primed for pharmaceutical-bashing by bird flu, the decision to cast the drug's industry as pantomime villains will strike a popular chord.

It's disheartening yet unsurprising that the public should suspect the worst when many of the big pharmas shroud their operations in secrecy.

The Constant Gardener star Ralph Fiennes says: "There are huge questions about big pharma. The companies are not obliged to disclose a lot of information about how they test or make their drugs. There's big, big money involved."

It would be easy for the drugs giants to dismiss their depiction in *The Constant Gardener* as false and far-fetched. It is just that – but surely a more constructive response would be to address the concerns raised over secrecy and look to engage and educate the public about the life-saving treatments which the pharmaceutical industry can deliver.

The ABPI view

It's fortunate that all pre-publicity for this film sought to emphasise its fictional nature because the image of the pharmaceutical industry presented is one I totally fail to recognise.

Early on we witness an AIDS education play being performed in a street theatre and soon after a character opines that "the pharmaceutical companies don't do anything for nothing". Given that companies including Abbott, GSK and Pfizer have been funding community education and counselling projects like the one highlighted in the film for many years, the line grates.

Later, a doctor incinerates a bottle of pills saying that medical donations are how the industry gets rid of its out-of-date medicines. Absolutely wrong. There are clear guidelines to ensure donated medicines fit needs and are well in date. Pharmaceuticals have donated medicines valued at over $4billion since 1998.

Where this film succeeds, however, is in its depiction of the extreme poverty that exists in areas of Africa.

A more sophisticated script would recognise that improving the health of people in the developing world is a complex issue. Only co-ordinated efforts from the international community can address these problems and pharmaceutical firms are taking an active role in assisting.

Andrew Curl, deputy director-general, ABPI.

E-mail your views to chemdrug@cmpinfomation.com

Here's to building on the success

Could I add to your report on the changes announced last week at Numark *(C&D, Oct 29, p6)*?

Phoenix is now the new owner of the company and has the absolute right to make whatever management changes it thinks fit. Changes at this stage when a new company takes over are common.

I would, however, like to pay particular tribute to David Wood, the previous chief executive, who I worked with very closely.

David Wood took over at a difficult time in 2001 but since then the company has developed strongly. Numark now has over 1,700 member pharmacies and sales of over £54 million a year. The Numark own brand has been developed outstandingly.

Above all, in 2004 Numark paid rebates of over £15m – an average of over £9,000 per membership pharmacy. Ten years ago Numark returned just £325,000 to members – or £396 per membership pharmacy.

In addition, David Wood was chief executive when Numark changed to a plc – three quarters of Numark members became shareholders – and also negotiated the successful sale to Phoenix.

The achievements of Numark over the last few years would not have been possible without his contribution.

It is vitally important that independent pharmacy should be strongly supported and I wish Numark and Phoenix the very best of fortune over the next years. I just hope it is remembered that whatever success Numark now gains will be on the foundations laid down by David Wood – and before him by Terry Norris.

Norman Fowler, chairman of Numark 1998-2005, House of Lords.

Letting the public know about MURs

I read with interest *Xrayser's* comment that 'MURs need a kick-start' *(C&D, Oct 29, p15)* – and his belief that a public awareness campaign was needed to remind patients and other primary healthcare colleagues of the medicine use review and prescription intervention services.

I agree. And I am pleased to assure *Xrayser* that the NPA is on to this. Our recently re-launched Ask Your Pharmacist national advertising campaign reminds consumers that many local pharmacists can provide a one-to-one consultation to review a patient's medication with them. Appearing across a wide range of women's magazines, our campaign messages are hitting all pharmacy's traditional consumer groups, with the aim of increasing awareness and demand for all services within the new contract.

To further increase patient awareness of the MUR service, in mid November we will be sending our members an MUR consumer awareness poster to promote the service to customers. We will also be encouraging members to make these posters available to local GP surgeries – and to explain the service to GPs if needed. This initiative will shortly be followed by an NPA MUR marketing pack, to support members in maximising MUR opportunities, and to continue to raise local public awareness of the service.

Xrayser may recall that in February the NPA produced a distance learning course – *From Prescription to Patient* – to prepare pharmacists to undertake the competency assessment required for accreditation to provide Advanced Service of Medication Use Review and Prescription Intervention. The response from our members in England and Wales was overwhelming, with nearly 1,000 applications received within the first 24 hours. Surely a clear indication not only of the NPA's proactive approach to preparing members to deliver this service, but also just how keen community pharmacists are to get involved.

Virginia Mead-Herbert, marketing director, National Pharmacy Association.

Our question to pharmacists this week was:
Which firework best represents the future of the pharmacy profession?

"Damp squib. It is a very uncertain time"

Dipak Shah, Sparkhill, Birmingham

"Rocket. I'm feeling very positive"

Arfon Bebb, Bangor, Wales

"Catherine wheel. I can't predict what the future is at the moment "

Mike Cornwell, Burnley

Our online poll at *www.dotpharmacy.com* said...


24%
Sparkler


17%
Cathering wheel


3%
Banger


13%
Rocket


43%
Damp squib

Comment from the Editor

A Bill of rights ... or wrongs?

As ever, legislation which could have a huge impact on pharmacy was barely noticed by the media last week.

All that hubbub over whether smoking should be allowed in pubs selling pork scratchings overshadowed the rest of the Health Bill. And for the record, we think the Government has been rather pathetic in not going for an outright ban on smoking in public. Of course, the working men's clubs from which the former health secretary might derive some of his support would disagree.

The Health Bill has been met with interest within pharmacy, although opinion as to its merits or potential threats has been hard to determine. It contains few surprises and, as the Bill is enabling, it lacks much of the detail that will be decided at a later date. The subsequent statutory instruments will be scrutinised carefully once tabled, although by that stage it could be a case that they will be rubber stamped without any parliamentary debate.

What may trouble some pharmacists – the 'final checkers' – are the proposals for supervision. What a difference the word 'direct' can have. The Bill will now give pharmacists the opportunity to work away from the pharmacy. Fortunately for some, this does not preclude pharmacists who insist on seeing all dispensed medication before it is given out from continuing to do so.

But the Government needs to be aware that while it presses ahead with allowing suitably trained pharmacy technicians to take on more responsibilities to free up pharmacists' time, PCTs have not yet worked out that pharmacists can and should be working more closely with patients.

Let's hope that their accountants don't see a potential saving: if pharmacy technicians can supply medicines, why pay for pharmacists?

"Pharmacists will have the opportunity to work away from the pharmacy"

Yourviews

E-mail your views to chemdrug @ cmpinformation.com

It's not the numbers, it's the message

I wish to respond to Ashwin Tanna's recent letter (*C&D, October 29, p14*).

No one understands the needs of independent pharmacists better than the NPA. Having said this, the NPA has never sought to speak exclusively for independents. It has traditionally done so because, during the NPA's history, independents have been the majority group within the community pharmacy sector. Even now, the NPA's board of management comprises a large majority of independents.

The NPA was established to represent - and provide services for - community pharmacy owners. The NPA is much better positioned to do this where it can be seen to be an inclusive body with a membership truly reflective of the sector as a whole. A large and inclusive membership gives the organisation strength and a provenance for speaking with authority for the whole sector.

We operate in a rapidly changing environment; community pharmacy faces huge challenges but also great opportunities, with a new contract providing a framework for making community pharmacy a central NHS player. Community pharmacy will be much better positioned to realise the opportunities presented in the new environment where it has behind it an organisation that is robust, flexible and adaptable. This is what the NPA serves to be.

In his letter, Mr Tanna warns us to learn from mistakes. One of the mistakes pharmacy has made repeatedly in the past is to present to opinion formers a fragmented and divided view. This seriously weakens pharmacy's position. What is needed is unity amongst pharmacy. This will not be measured by the number of bodies purporting to represent the sector but the collectiveness of the message.

John D'Arcy, chief executive, National Pharmacy Association.

Northern Ireland NOTEBOOK

TOPICAL REFLECTIONS

Out of stock and out of excuses

Stock control is an important part of my business and something I pride myself on doing well. A thorough knowledge of the workings of my business and customers' habits, combined with anticipation of seasonal influences and the effects of other factors such as marketing and product innovation, means that I usually have the right stock in the right place at the right time. Without this expertise I would probably go out of business.

So it beats me how manufacturers can apparently get some of these basic principles so wrong, yet continue to make incredible profits. Every community pharmacist in the country is painfully aware of the current long list of dispensary out of stocks yet I have heard no credible explanation for this problem. There must be one, unless a lot of employees have simply simultaneously got their stock control measures wrong.

A particularly bizarre example of poor stock control seems to be the fact that GSK's Infant Aerochamber spacer device is now out of stock. I assume this is due to the increased demand for the product as a result of patients switching from the recently discontinued Paediatric Volumatic to an Aerochamber.

What is particularly odd is that GSK used to make the discontinued Volumatic and so should have a very clear idea of the size of the demand for its replacement. It knew exactly when stocks of the old Volumatic would run out and should have been able to accurately predict seasonal and marketing driven demand for the new product.

I wonder if GSK has simply become complacent in an area where it has no competition. Until the situation is resolved patients will not be switched to an alternative product, but will simply go without. The end result is that GSK loses no business but patients may suffer.

The burden of responsibility for out of stocks must somehow be laid squarely to rest on the manufacturers' themselves. Perhaps if the Department of Health introduced a system of fines for the manufacturers responsible, they would occur less often. A more severe fine would be appropriate for therapeutic areas with few alternative treatments.

McHare beats Tommy Tortoise again

Cartoon by Don Sneed

Pharmacy in Scotland seems to race ahead in a well co-ordinated and progressive manner while the profession in England struggles to keep up and remains mired in politics. The proposed merger of the Scottish Pharmaceutical General Council and the Scottish Pharmaceutical Federation to form a single representative body for the profession north of the border (*C&D, October 29, p5*) sounds like a great idea and is light years ahead of the situation in England.

Would English pharmacists be better represented by a merger between PSNC and the NPA? Of course we would, but instead of streamlining our administration we are discussing how many more representative bodies we can form. In addition to assorted existing factions, we're discussing the formation of an Independent Pharmacy Forum and even a body to represent locums (*C&D, October 29, p16*). Whatever next – the Association of Middle Aged Pharmacists, or even the Blue-Eyed Pharmacy Federation?

I wonder if we will always be the tortoise compared to the Scottish hare. After all, apart from our obviously larger size, why should pharmacy in England be so different? Scotland still has multiples, independents, locums and a range of other vested interests yet they seem to work together effectively to get things done. Scotland is streets ahead on issues like ETP and payment for services. It appears that Scottish pharmacists have the ear of their ministers, are driving their own agenda, and are fairly remunerated for their efforts. But perhaps if I stopped complaining about what I haven't got and concentrated on the opportunities I do have, I could remove my tortoise shell and step into a nice fluffy hare outfit.

Too big for their Boots

Independent community pharmacists in Northern Ireland have shared the same healthy suspicion that counterparts in Great Britain have had for Boots and its predatory activities.

The recent bombshell that an alliance with UniChem is planned came as a shock but with little real understanding of what it might all mean should it eventually come about.

UniChem, with 50 plus pharmacies here, joining with Boots, also with 50 plus, means the new company, Alliance Boots, will control over 25 per cent of our pharmacy contracts; more than the 17 per cent of contracts overall that the new company will control. I know little about monopolies and the laws that govern them or indeed what constitutes a monopoly but I fear that the influence Alliance Boots will bring to the Northern Ireland pharmacy market will be unhealthy.

Consideration must be given to making early representation to the Monopolies Commission. Be in no doubt there are already growls echoing in the forest.

Boots has not been doing well lately which is, of course, the primary reason for the merger. As for UniChem, it seems to be of a suitably frightening size, the sort you would like with you when you go on the prowl.

Boots's strategy over recent years has been confusing to say the least. Its expansion beyond the traditional fields made little sense to me but did give me breathing space as it prowled elsewhere. Now it finds these hunting grounds less productive than expected it's returning to home pastures. For independents, it's time to keep eyes pealed, ears focused and not to stray too far from your burrow because Alliance Boots will use its teeth to eat into your business.

As independents we also have strengths: we're faster, more flexible and agile. We need to play to these strengths if we want to avoid getting gobbled up.

Written by a community pharmacist practising in Northern Ireland

E-mail your views to chemdrug@cmpinformation.com

Been there, done that: the Pharmacists' Defence Association came first...

It was with a great deal of sympathy that I read David Morgan's letter regarding the isolation felt by large numbers of locums (*C&D, October 29, p16*). I share those concerns because having worked as a locum for 12 years, it made me realise that the concerns of locums and employees generally were being overridden by the increasingly powerful voice of the large employer that was dominating the profession.

Like David Morgan, I began to think that locums and employees generally needed to have their own organisation. This idea was further validated when I became an RPSGB Council member in 1997 and I saw the huge influence that the large employers had on the affairs of the Society.

That is why I am so surprised that David Morgan should think that the NPA – increasingly a large employer organisation – would be a suitable vehicle to take on the role of looking after locums. Does he not realise that the actions of Kirit Patel and Graham Phillips (previous NPA Board members) to set up the Association of Independent Multiples (AIMp) and the Independent Pharmacy Federation (IPF) respectively, came directly as a consequence of their first hand realisation that the NPA has now become an organisation that is led by large multiple interests and can no longer properly look after their distinct interests.

Ashwin Tanna in his article last week (*C&D, October 29, p14*) alluded to the fact that the NPA relies on the multiples for its financial stability; it is little surprise that if one or two multiples pay very large subscriptions to the NPA, then they will be given a much greater say in the affairs of the NPA. While there is little doubt that the NPA would covet the possibility of earning some extra income from a locum association, as an employer organisation it will never have the philosophy nor the deep rooted passion to actively pursue a locum agenda as this would invariably conflict with the interests of its core constituency – the owners of pharmacies.

Sadly, David Morgan's suggestion for the NPA to lead a locum association would not produce any worthwhile solutions for locums. Moreover, strategically a locum association operated by a multiple-led organisation could be truly catastrophic for locums. What, for example, will happen the first time the association wants to talk about pay and contractual conditions or wants to develop an agenda that conflicts with that of the employers?

My experiences as a locum and RPSGB Council member led to the creation of the Pharmacists' Defence Association in 2003. A primary aim was to begin to redress the imbalance created by the domination of the employer interest in pharmacy and for the first time to really push the agenda of the individual pharmacist, be they employee or locum.

Since launch, the PDA has attracted almost 11,000 members, 4,500 of whom are locums, which is the majority of all locums in the UK. This has enabled us to employ full time office based pharmacists, lawyers and admin staff and also an extensive board consisting of 15 experienced pharmacists and lawyers.

"Each week we assist hundreds of locum and employee pharmacists"

Each week we assist hundreds of locum and employee pharmacists who require advice on a wide range of professional, ethical, employment and self-employment issues. As David says, we have performed "usefully" in employment issues, claiming more than £150,000 in compensation from employers who have treated their employees harshly, in our first year alone. He may not be aware, however, that we have also secured payments in excess of £50,000 for locums from employers who are often NPA members and who have refused to pay them, either at all or in part, their fees due for contracted services. And yes, we have fought with the NPA in tribunals and elsewhere where they have ably defended the interests of employers and we have ably pursued the interests of employees and locums. This is how it should be, one organisation for employers and one for employees and locums with no conflicts of interest.

What David may not realise is that the PDA is also dealing with a plethora of professional issues too. In one year we developed policy and lobbied the relevant authorities on issues as wide ranging as staffing levels, pharmacist workload, violence in pharmacy, the new RPSGB criminal declaration – subjects dear to David Morgan's heart.

Next year the PDA will be launching its plans for the individual pharmacist NHS contract, putting in submissions on the forthcoming Section 60 Order consultation and the new Code of Ethics re-draft and will also be looking to fend off the threat from the Government's plan to allow pharmacies to run in the absence of pharmacists (a great cost saving for the multiples). We know that we are putting forward the views of individual pharmacists because the PDA generates its policy through focus group meetings, questionnaires and conferences where these issues are debated with employee and locum pharmacists.

We share the view that locums need an association to look after their interests; in the Pharmacists' Defence Association such an organisation already exists and we urge all locums to join.

Mark Koziol MRPharmS, chairman, The Pharmacists' Defence Association.

... and supports the locum, not the employer

I was angered to read David Morgan's letter (*C&D, October 29, p16*) in which he mentions that the NPA should form a locum organisation.

I am a locum who recently had the misfortune of having to take my employer to a tribunal as I felt my contractual rights were being ignored.

The experience was a frightening one and to make matters worse I had to face two legal experts sent along by the NPA to support their member – the employer.

Thankfully I am a member of the PDA and with its support I managed to secure compensation of more than £600 from the employer.

This experience taught me that the NPA is a body that looks after the interests of the employers. These are not the same interests as those of the locum and so the NPA should stick to looking after owners and not locums.

A locum association run by the NPA, whatever next? Turkeys accepting an invitation to Christmas dinner?

Name and address supplied.

Drug excretion: the main route

In the second of two articles on drug excretion, *Danny Burke* explains the urinary route

This article addresses urinary excretion and the transport proteins that pump drugs from blood into liver and kidney cells, and from these cells into bile and urine respectively. The previous article covered drug excretion in the bile and faeces and several minor routes of excretion (*C&D, October 29, p17*).

Excretion into the urine via the kidney is the major route for most drugs and their metabolites.[1] However, because lipid-soluble compounds are reabsorbed by the kidneys, the parent drug molecules and their phase 1 metabolites are generally extensively reabsorbed from the kidney into the blood without reaching the bladder. However, more water-soluble phase 2 drug conjugates are only minimally reabsorbed and pass on into the urine. Consequently, drugs are excreted in urine mainly as their conjugates.

Most drugs are ultimately detoxified by a combination of metabolism in the liver and excretion via the kidney or faeces. Some drugs, however, are detoxified almost entirely by urinary excretion of the parent drug without any prior metabolism. Examples include ampicillin, furosemide, gentamicin and methotrexate. Any alteration or impairment of kidney function can have a major impact on their efficacy and toxicity of such drugs.

The smallest functional unit of the kidney is the nephron, a tubular apparatus in which the urine is made (as a filtrate and secretion of water, salts and organic compounds from the blood) and down which it flows to the bladder. The nephron interfaces with renal blood vessels along almost its whole length.

There are five main parts to the nephron. At its head sits the glomerulus, then going downstream there are, in succession, the proximal tubule, the loop of Henle, the distal convoluted tubule and finally the collecting tubule. Each of these plays a unique function in urine formation. It is a measure of the biochemical activity of renal tubule cells that they have among the highest oxygen consumption of any cells in the body.

Drug excretion by the kidney involves three main processes:

- Glomerular filtration.
- Active proximal tubular secretion.
- Passive distal tubular reabsorption.

Glomerular filtration

The two kidneys constitute less than 1 per cent of the total body weight, but receive about 25 per cent of the cardiac output. They process the entire volume of circulating blood in the body every five minutes and their glomeruli convert up to 20 per cent of the renal blood flow into a filtrate which is the nascent urine.

The glomerular filtration rate (GFR) of a healthy individual is about 120ml plasma water/minute, equivalent to 180 litres/day or approximately 1.8ml/min/kg body weight. Anything significantly less implies impaired glomerular function. About 99 per cent of the water and salts in the glomerular filtrate are reabsorbed from the nascent urine during its passage down the nephron, so that the daily urine output is only around one to two litres a day.

The glomeruli readily pass most drugs into urine, but only drug molecules that are not bound to proteins – because they are filtered through a 40Å diameter capillary pore. Accordingly, compounds of molecular weight greater than 60,000, which include protein-bound drugs, are excluded by healthy glomeruli, and the presence of albumin (MW 68,000) in the urine implies kidney damage.

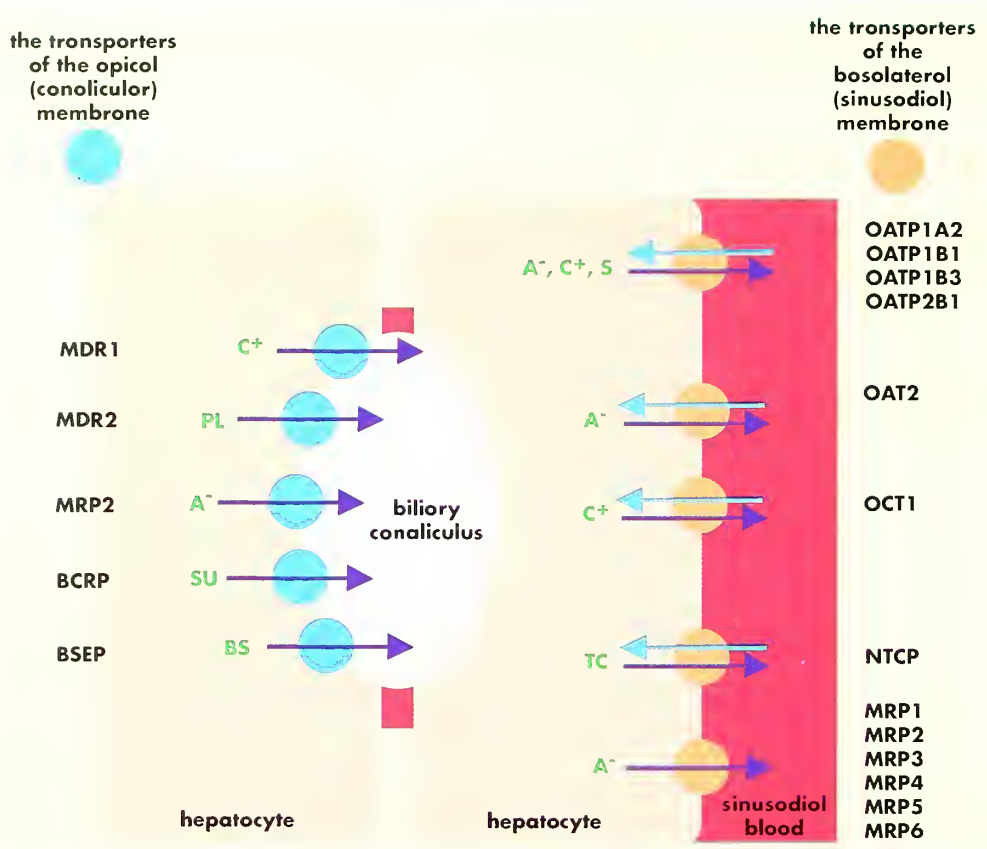
GFR is usually measured by the clearance of the non-protein bound, physiological substance creatinine (MW 131), which is excreted only by glomerular filtration and is neither reabsorbed nor secreted lower down the

Continued on page

John Bavosi/Science Photo Library

Illustration of a nephron from the human kidney, surrounded by blood vessels. Nephrons are where waste products and excess water are removed from the bloodstream in the kidney. Around 140 litres of fluid passes into the kidney tubules each day in a normal adult. Of this, 99 per cent is reabsorbed

Figure 1: Drug transporter proteins of the liver hepatocyte cell



The transporters are located selectively either in the basolateral membrane abutting the sinusoidal blood, or in the apical membrane which lines the biliary canaliculus. The transporters pump drugs and physiological compounds either bidirectionally or unidirectionally across the membranes. The ligands that are transported (green lettering) are: A- negatively charged organic anions; C+ positively charged organic anions; S neutral steroids; BS bile salts; PL phospholipids; SU sulphate conjugates; TC taurocholate. In hepatocytes the basolateral transporters include several different types of SLC proteins, such as OATs (organic anion transporters), OCTs (organic cation transporters) and OATPs (organic anion transporting polypeptides, which also transport some cationic drugs and neutral steroids), and also some ABC proteins, for example MRPs (multidrug resistance associated proteins, also called MOATs, multispecific organic anion transporters). The basolateral OATs, OCTs and OATPs pump drugs bidirectionally, both from blood into the cell and back again, whereas the basolateral MRPs pump only unidirectionally, from the cell back out into the blood. Those drugs and metabolites that are pumped from the hepatocytes back into the blood can then flow down to the kidneys for excretion in the urine. The apical transporters of hepatocytes are solely ABC proteins, operating unidirectionally as efflux pumps from cell to bile. They include MRPs, MDRs (multidrug resistance proteins, including the best known drug transporter, P-glycoprotein or MDR1, which are cation pumps), BCRP (breast cancer resistance protein) and the bile salt pump, BSEP (bile salt export pump). MDR1 typically transports drugs that have cationic groups, including cyclosporine, digoxin, fexofenadine, paclitaxel and verapamil. MRP2 requires glutathione for its activity and transports drugs containing anionic groups into the bile, including their glucuronide, sulphate and glutathione conjugated metabolites. BCRP may excrete sulphate conjugates. Further examples of drugs that are pumped into the bile include diazepam, doxorubicin, indomethacin, paracetamol, rifampicin and vincristine. MDR1 and MRP2 are induced by rifampicin[7], and MRP3 is induced by omeprazole[11]

kidney tubule. Fluconazole and ofloxacin are eliminated almost entirely as unmetabolised parent drugs in urine via glomerular filtration, and in patients with impaired kidney function the drugs' half-lives increase as creatinine clearance decreases.[2]

Active proximal tubular secretion

The majority, some 80 per cent, of renal blood flow escapes filtration by the glomeruli and is, instead, presented to the proximal tubules. Many drugs are actively secreted from this blood into the urine by the proximal tubules, using an energy-dependent process of carrier-mediated active transport. Ciprofloxacin, for example, undergoes both glomerular filtration and tubular secretion, whereas captopril enters the urine almost entirely via tubular secretion.[2]

There are two different sets of carriers, one for acidic drugs, including glucuronide and sulphate conjugates, and the other for basic drugs. Different drugs can compete for the same carrier system and mutually inhibit each other's secretion, for example probenecid inhibits the secretion of penicillins while sulphonamides inhibit the secretion of indometacin. As a mechanism of excretion, renal tubular secretion is more important for acidic drugs than for basic drugs.

The most important pharmacological characteristics of tubular secretion are that it is fast, can efficiently secrete even drugs that are protein bound, and can secrete drugs against a concentration gradient. The result is that tubular secretion can almost completely clear renal blood of many drugs irrespective of the extent of their protein binding (*Table 1*). For example, penicillin is 80 per cent bound to plasma protein but is almost completely removed from the blood by proximal tubular secretion.

The rate of tubular secretion of drugs is governed by renal blood flow (normally around 600ml/min), which can be measured by the excretion of para-aminohippuric acid, because this is excreted purely by tubular secretion.

Passive distal tubular reabsorption

Drugs in the nascent urine that are very lipid-soluble are reabsorbed into the blood as they pass down the distal convoluted tubule. Consider a drug that is filtered by the glomeruli from the renal blood into the nascent urine. Initially, at the top of the nephron, the drug concentration in the nascent urine is the same as in the renal blood. But because over 90 per cent of the water is reabsorbed during passage down the nephron, by the time the nascent urine reaches the distal tubule its drug concentration will be about 100 times higher than in the blood. It is the energy of this concentration difference that drives the passive process of tubular reabsorption of the drug back into the blood.

Certain drugs are too water-soluble to be reabsorbed and so pass through into the urine proper, for example digoxin and the aminoglycoside antibiotics. The glucuronide and sulphate conjugates of most drugs are also too water-soluble to be reabsorbed, which is the main reason why phase 2 metabolism (that is, conjugation) facilitates drug excretion.

Many drugs are weakly acidic or basic. For these, the pH of the nascent urine can have a marked influence on the amount of the drug excreted. For example, the proportion of a dose of methamphetamine that is excreted in urine as parent drug is around 45 per cent in normal urine of pH 6-8, but as little as 2 per cent in alkaline urine (pH >8) and as much as 76 per cent in acidic urine (pH <5).[3]

Weakly basic drugs such as amphetamines become more ionised in acidic urine - and the ionised form is more water-soluble and therefore less reabsorbed from the kidney and more excreted in the urine – while in alkaline urine they

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www.diabetesnow.co.uk

Abbott Laboratories Ltd., Abbott Diabetes Care,
Mallory House, Vanwall Business Park, Maidenhead SL6 4UD.

GE33 0805 v1

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become less ionised and therefore more lipid-soluble, more reabsorbed and less excreted.

Patients have been known to take a large amount of sodium bicarbonate with amphetamine in order to alkalinise their urine with the intention of prolonging the drug's effect.[4] This characteristic of the kidney can be made use of in the emergency treatment of overdoses of weakly acidic drugs, by deliberately manipulating the pH of the nascent urine so as to increase the drug's ionisation and enhance its excretion. For example, urinary excretion of the weakly acidic drug, phenobarbital, can be deliberately accelerated for overdose treatment by making the urine more alkaline through the intravenous administration of sodium bicarbonate.[5]

Drug transporter proteins

Intracellular drug transporter proteins play a major role in determining which route of excretion – urinary or biliary – a drug and its metabolites go down. The differing predilections of drugs for secretion by renal tubules into urine or by hepatocytes into bile is explicable by the directional fluxes, substrate specificities and cellular distributions of drug transport proteins (*see figures 1 and 2*).

There are two main types of proteins that transport drugs across liver and kidney cell membranes: the ABC transporters and the SLC transporters (ATP binding cassette transporter proteins and solute carrier transporter proteins respectively).[6] A wide range of drugs are ligands for these transporter proteins and are transported by them.[7-9] Each of the different transporters is specific to a particular range of drug structures, although these specificities are broad and are to some extent shared between different transporter proteins (the specificities are said to be "broad and overlapping").

Most transporters specifically pump either negatively charged organic anions or positively charged organic cations, including drugs. The transporters are single protein chains, typically comprising around 600 amino acids configured as a sequence of up to 12 helical coils, which are embedded in and span the cell membranes that divide either the hepatocyte liver cell from the blood and the bile canaliculus (bile channel) or the kidney tubule cell from the blood and the nephron.

The ABC proteins accomplish the ATP-powered active transport of drugs across cell membranes. Some SLC proteins also carry out active transport, but this is energised by the transmembrane flux of sodium or other cellular ions. Other SLC proteins are instead responsible for that biochemical mystery, facilitated diffusion, in which they carry drugs across cell membranes via a mechanism that is energised by a favourable drug concentration gradient (that is, the drugs move only from a higher to a lower concentration).

There are scores of different transporter proteins in humans and there is a gene for each one. The nomenclature is confusing as different laboratories give different names to the same proteins. The major physiological role of these proteins appears to be the transportation of many different types of endogenous molecules, and the transport of drugs is probably a mere happenstance, albeit one of monumental importance for modern medicine.

Liver hepatocyte and kidney tubule cells are polarised, that is their basolateral membranes, which adjoin the blood vessels, are chemically and functionally different from their apical membranes, which adjoin the lumen of the bile canaliculi or kidney nephrons. For a drug to be excreted in bile or urine it must first cross a basolateral membrane to enter the hepatocyte or kidney tubule cell from the blood, then cross an apical membrane to exit the cell into the bile or urine.

The key to the role of the drug transporters is that some are located in the basolateral membranes and others are located in the apical membranes.[7-9] The basolateral transporters pump drugs and metabolites from the blood into the liver or kidney cell (and sometimes back again) and manage in the process to strip drugs from their plasma binding proteins. This protein stripping is significant, because in the contrasting passive diffusion of drugs across membranes (which does not involve transporter proteins and in which drugs of a sufficient lipid solubility move down a concentration gradient) only the free or non-protein-bound fraction of the drug diffuses.

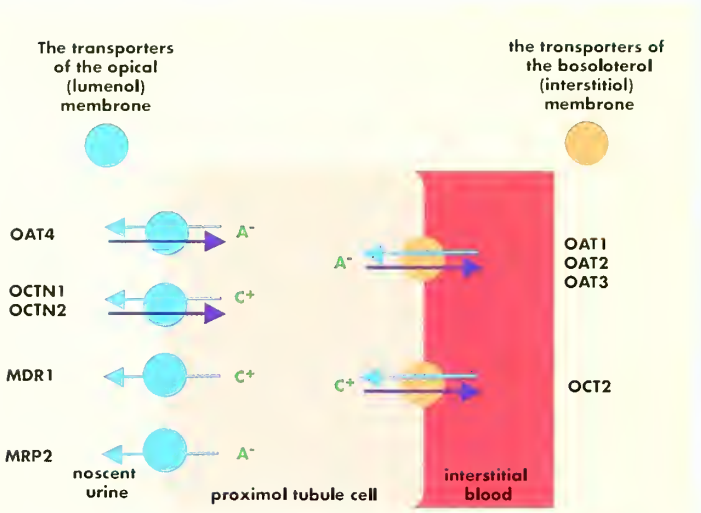
The apical transporter proteins pump drugs and their metabolites in one direction only, from the cell into the bile canaliculus or kidney nephron. It is the ligand specificities and organ/membrane locations of the various transporters that help determine whether a drug undergoes urinary or biliary excretion.

It is emerging that, as with CYPs, some of the ABC and SLC drug transporter proteins can be inhibited or induced by drugs and exhibit genetic polymorphisms that modify their activity.[7,10] Henceforth the understanding of drug interactions and genetically based interindividual variations in efficacy will have to take ABCs and SLCs into account along with CYPs.

References available on the C&D website: www.dotpharmacy.com

Danny Burke is emeritus professor of pharmaceutical metabolism at the University of Sunderland and has published over 200 research articles on CYP and drug metabolism.

Figure 2: Drug transporter proteins of the kidney tubule cell



The transporters are located selectively either in the basolateral membrane abutting the interstitial blood, or in the apical membrane which lines the lumen of the nephron. The transporters pump drugs and physiological compounds either bidirectionally or unidirectionally across the membranes. The ligands that are transported (green lettering) are: A- negatively charged organic anions; C+ positively charged organic anions. In kidney proximal tubule cells the localisation of drug transporters is less well documented than in hepatocytes. Bidirectional anion-transporting OATs and cation-transporting OCTs are present in the basolateral membrane, while the apical membrane includes unidirectional MDR cation pumps and MRP anion pumps. In addition the kidney apical membrane contains bidirectional transporters, OCTs and an OAT, which appear able to pump drugs in either direction, secreting them from cell to lumen of the nephron and reabsorbing them back into the cell

Table 1: Some drugs that are actively secreted by the renal proximal tubule[2,12]

Acetazolamide
Amantadine
Amiloride
Atropine
Bumetanide
Captopril
Carbachol
Cephalosporins
Chlorpropamide
Cimetidine
Ciprofloxacin
Dopamine
Ethambutol
Furosemide
Glucuronide conjugates
Indometacin
Lithium
Loop diuretics
Meperidine
Mepacrine
Metformin
Methotrexate
Morphine
Neostigmine
Penicillins
Pethidine
Phenytoin
Probenecid
Procainamide
Procaine
Quinine
Salicylic acid
Sulphate conjugates
Sulfinpyrazone
Sulphonamides
Thiazide diuretics
Trimethoprim
Triamterene
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Combination therapies more effective in RA

Rheumatoid arthritis patients on combination treatments benefit from less joint damage progression and earlier functional improvement, say Dutch researchers.

Over 500 patients with very early RA were randomised to receive one of four commonly prescribed treatment strategies: disease modifying antirheumatic drugs (DMARDs), starting with methotrexate; step-combination therapy, starting with methotrexate then adding other DMARDs and prednisone; combined prednisone, methotrexate and sulfasalazine; or combined methotrexate and infliximab.

Although all groups showed improvement by the end of a year, including 32 per cent of patients achieving clinical remission, patients in both initial combination groups experienced more rapid symptom relief and had less radiographic joint damage than participants in the other two study groups. Similar levels of side effects were reported by all four patient groups.

For more information:

Arthritis & Rheumatism; 52: 3381-3390

More work needed on LRAs, says DTB

The *Drug and Therapeutics Bulletin* has called for more research into the advantages offered by leukotriene receptor antagonists (LRAs) to different patient groups.

The drug class – which includes montelukast and zafirlukast – comprises an option for people with exercise-induced bronchoconstriction, says the *DTB*. However, the occurrence of such symptoms may indicate inadequate asthma control and should prompt a broader review of preventative treatment, it adds.

Citing another treatment area, the publication says that evidence has shown LRAs to offer fewer clinical benefits than inhaled long-acting beta-agonists when used as an add-on therapy in asthmatic patients. Therefore, an inhaled LA beta-agonist should be tried first, except in children under five years, in whom only montelukast is licensed and of known efficacy, it points out.

The *DTB* first reviewed LRAs when they were launched in 1998, and concluded that there was no clearly defined role for the medicines. On this occasion, it concludes that licence extensions and recently published research findings have strengthened the drugs' therapeutic position, but more research is still needed.

For more information:

DTB 2005; 43: 85-88

New malaria regimen found

Trimethoprim combined with sulfamethoxazole (TS) is a highly effective form of malaria prophylaxis, says a paper in this month's *Journal of Infectious Diseases*.

The researchers assigned 160 children aged between five and 15 years living in Mali to receive TS and 80 to receive no medication. The TS prophylactic regimen proved 99.5 per cent effective against uncomplicated malaria, and patients in this group experienced fewer gastrointestinal illnesses and required fewer prescription medicines than the participants in the control group.

For more information:

JID 2005; 192: 1823-9

WHO/P.Virot

A boy suffering from malaria

Scriptlines

Enmix Plus Commence

A nutritional drink initiation pack has been launched by Abbott Nutrition.

Enmix Plus Commence contains the most popular flavours of Ensure Plus, both in milkshake and yoghurt formulations, and Enlive Plus. ACBS approved, the mixed case comprising 10 cartons is NHS-prescribable for patients with disease related malnutrition.

Abbott says the product gives patients the ability to sample a wide range of different styles and flavours to decide what they like before a prescription is written. This approach will ensure prescribing is led by patient preference, not random sampling, and will reduce wastage and increase compliance, it adds.

Price: £16.18

Pack size: 10 cartons

Pip code: 285-3349

Abbott Nutrition

Tel: 01795 580099

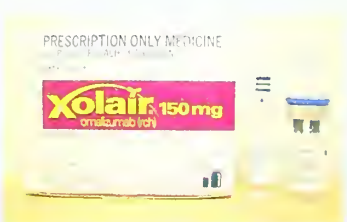
Xolair injection

Novartis Pharmaceuticals has launched Xolair (omalizumab), an add-on therapy for patients with severe persistent allergic asthma.

The monoclonal antibody is licensed to improve asthma control in patients aged 12 years and over who have tested positive to a perennial aeroallergen and have reduced lung function (FEV_1 below 80 per cent). In addition the SPC states that, to be considered for Xolair treatment, patients must have frequent daytime symptoms or night-time awakenings, and multiple documented severe asthma exacerbations despite using daily high-dose inhaled corticosteroids and a long acting inhaled beta-agonist.

Appropriate dose and dosing frequency is determined by measuring body weight and IgE level before treatment, as patients with an IgE lower than 76 IU/ml are less likely to benefit from Xolair.

The recommended dosing range is 75-375mg omalizumab in one to three subcutaneous injections every two to four weeks. The maximum recommended dose is 375mg every two weeks. According to the SPC, the most common side effects include injection site reactions and headache.



Price: £256.15

Pack size: Vial containing 150mg omalizumab powder plus solvent for injection

Pip code: 318-7432

Novartis Pharmaceuticals UK Ltd

Tel: 01276 692255

Aci-Jel

Janssen-Cilag is discontinuing Aci-Jel vaginal jelly (glacial acetic acid) globally from the end of December for "manufacturing reasons".

For more information:

Janssen-Cilag Ltd

Tel: 01494567567

Noxafil

The European Commission has granted marketing approval to Noxafil (posaconazole) for the treatment of certain serious fungal infections, says Schering-Plough.

The company's marketing application covered the oral suspension's use in adults with disease that is refractory to, or who are intolerant of, commonly used antifungals. Clinical trials have demonstrated posaconazole's broad spectrum of activity against yeasts and moulds responsible for serious invasive fungal infections, such as aspergillosis, which occur most commonly in immunocompromised patients.

For more information:

www.schering-plough.com

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STOCK UP TODAY

Unilever

A hands down win for Dettol

Dettol has launched a new range of antibacterial handwashes available in three fragrances.

Manufacturer Reckitt Benckiser claims the handwash is so successful at killing germs it outperforms its nearest competitor by over 400 per cent. This enables the product to fight the spread of germs and infections, the company says.

Recent research quoted by Dettol found 67 per cent of liquid soap consumers rated an anti-bacterial agent as a top priority.

The handwash comes in three fragrances. Moisture: Aloe Vera and milk protein; Refresh: grapefruit extract and vitamin and Soothe: lavender and grape extract.

It will be supported by a £3 million TV advertising campaign, on air in January. There will also be in-store promotions.

Price: £1.99 (250ml pack)

Pip code: Moisture: 317-5676, Refresh: 317-5668, Soothe: 317-5684
Reckitt Benckiser Household
Tel: 01793 732000

Get switched on to Sudafed

Sudafed has introduced a new vapour plug which it says provides a non-medicinal solution for clear and easy breathing.

The mini, waterless vapour continuously releases up to eight hours of comforting aromatic vapours including menthol and eucalyptus, says manufacturer Pfizer.

The vapour plug launch is being supported by a £3 million TV advertising campaign, and print and in-store promotion.

Price: One plug and five refill pads: £4.90 316-4548 Pack of five refills: £3.49 316-4852

Pfizer Consumer Healthcare
Tel: 01304 616161

Get the best talons in town

Groomed and glamourous nails are possible this winter according to Coty, following the launch of its new nailcare range.

Containing everything needed for perfect nails, the company says the four-step collection will help prevent split and broken nails.

It consists of a base coat, strengthener, top coat and French manicure polish that comes in three shades: ivory, white and rose.

The nailcare range is available in multiple and independent chemists nationwide.

Price: £1.99 per bottle

Coty
Tel: 020 8971 1300

Multibionta goes into action

Multibionta is promoting its newly launched Activate probiotic, a supplement aimed at people with hectic and stressful lifestyles.

This winter's TV campaign focuses on Activate's formula of probiotics, multivitamins and minerals, ginseng and CoQ10, which Seven Seas says has a triple effect to boost energy levels.

The advert features a day in the life of a young man and woman with healthy, active lifestyles, and is part of a £3.5 million support package allocated by Seven Seas for the Multibionta brand. It will be aired across terrestrial and satellite channels from this week, and supported by a high-impact outdoor advertising campaign.

For more information:

Seven Seas Health Care Ltd
Tel: 01482 375234

OXY wipes up in teen spot market

Teen skincare brand OXY has unveiled its new OXY Triple Action Wipes with zinc.

The wipes are formulated for use twice a day and will clean the skin, destroy spot-causing bacteria and prevent spots, the manufacturer says. It claims the active ingredient, zinc PCA, destroys spot-causing bacteria, and the wipes are more convenient than other skincare products that involve rinsing and cotton wool.

The dermatologically tested wipes can be used on the face and body, alone or in conjunction with other products in the range.

The launch is part of a major brand re-vamp for OXY, celebrated by asking teenagers to dream up an idea for a new £1 million ad campaign. The winning creative will be shown on Channel 4 and MTV this autumn.

Price: £3.69 (per 25-wipe pack)

Pip code: 316-6998
Mentholatum Co Ltd
Tel: 01355 848484

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CONTACT NAME _____

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Please fax this entire page back to Scholl Footwear on 0161 615 8800, or post the tear-off to Scholl Footwear plc, SSL International, Venus, 5th Floor, No.1 Old Park Lane, Trafford Quays, Manchester M41 7HA.

Detox your nails with Cutex

Ultra Cleansing nail polish remover is the latest release from Cutex.

The formula quickly dissolves hard-to-remove nail polish and cleans away stains, says Cutex.

Ultra Cleansing remover contains a multi fruit acid complex to clean away oils and residues, green tea extract to soothe irritations and vitamin E to nourish and mositurise, the manufacturer adds.

It is available in either 100g or 200g bottles and is now available from Lloydspharmacy and independent pharmacies.

Price: 100g £1.49 (317-5981)
200g £1.99 (317-5999)
Coty (UK) Ltd
Tel: 020 8971 1300

TV

Abbott Diabetes Care: GMTV, Sat

Ambi Pur: All areas except U

Covonia: five, GMTV, Sat

Cura-Heat Back Pain: All areas except LWT, GMTV, Sat

Cura-Heat Arthritis Pain, Knee & Wrist: All areas except LWT, GMTV, Sat

Just for Men: All areas

Kalms Sleep: All areas except GMTV

Lloydspharmacy raising awareness of its free repeat prescription collection service: All areas except LWT, GMTV

Nytol: All areas

Seven Seas Cod Liver Oil: C4, Sat

TENA Lady: All areas except U, CTV, LWT, GMTV

TENA Pants Discreet: All areas except U, CTV, LWT, GMTV

ThermaCare: All areas except GMTV

Vagisil Medicated Crème: G, C, HTV, W, five, GMTV, Sat

Vicks First Defence: All areas except GMTV

WindSetlers: five, GMTV

Ymea: G, C, HTV, M, GMTV

Zovirax Cold Sore Cream: C4, five, Sat

PharmaSite for next week: Panadol – Window, **Asilone –** In-store, **Vicks First Defence –** Dispensary
Pharmacy channel: Isovon, Paramol

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Smoothaway nappy rash

Nelsons has a new addition to its natural kids range – a nappy rash cream called Smootha.

Made with a blend of natural plant extracts, Nelsons says the product is gentle, safe and specially formulated to care for a baby's sensitive skin.

The manufacturer claims Smootha works naturally to provide a protective barrier on delicate skin and replenish moisture resulting from nappy rash.

Its 50g tube is also being promoted as the ideal size to transport in changing bags.

The product launch will be supported by an advertising campaign in women's consumer magazines and the parenting press.

Smootha joins Nelsons' other children's products, Teetha and Sootha, for teething and coughs respectively.

Price: £5.50 (50g tube)
Pip code: 317-1295
Nelsons
Tel: 020 8780 4200

A good night's sleep is not a dream, says Nytol

Sleep aid Nytol is featuring in a £1.5 million marketing campaign this winter, with its manufacturers claiming it can help people drift gently off to sleep.

Back on national TV for the second time this year, adverts will run from November 7 for seven weeks. Around half the slots will target consumers after 9pm, when the message is most resonant.

A 20-second strip of the existing 'Dreamland' advert will be shown on terrestrial and satellite stations and on the Life Channel TV in GP surgeries.

The ads will feature the full range of Nytol products and the familiar sign-off "Good mornings follow a good Nytol".

Print adverts will appear in a combination of monthly and weekly magazines including *OK!* and *Good Housekeeping* from November until mid-December.

And a 13-week radio campaign will run during this time, through the sponsorship of late night and early morning radio on regional stations around the country.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 5000

Zovirax prepares for winter

GlaxoSmithKline is promoting Zovirax cold sore cream during its key selling period as winter draws in.

A national TV campaign will involve the third screening of the 'Helmet' ad this year. This features a woman disguising her face until she discoverers Zovirax cold sore cream, allowing her to confidently reveal her identity again.

GSK, which has spent over £2 million this year promoting the product, says nothing works faster at treating cold sores than Zovirax.

The ad will screen from November 7 until the end of December, in a two-week-on, two-week-off campaign on terrestrial and satellite stations.

The TV burst will be reinforced by a national press campaign due to start in December and run through to February.

For more information:
GlaxoSmithKline Consumer Healthcare UK
Tel: 020 8047 5000

BIO-FEM donates money for health research

BIO-FEM is donating 20p from every purchase of its vaginal discomfort remedy Actigel to charity.

The company has teamed up with charity Wellbeing of Women (WoW) to raise awareness about women and issues surrounding their bodies.

WoW is a UK charity supporting research into women's reproductive health. The money raised will fund research to diagnose, treat and ultimately prevent these health problems.

Actigel is a natural gel made from plant extracts that may help to prevent thrush and ease bacterial vaginosis, says the manufacturer.

Price: £7.95
Passion For Life Healthcare Ltd
Tel: 01372 847272

Hard as nails

Say goodbye to chipped nails with Rimmel's new 'shockproof' Lycra Wear nail polish, which offers up to five-day durable colour and a high-shine finish.

It comes in four different shades: grape sorbet (pink); hot gossip (red); goldspun coral (peach) and magnolia pearl (pale oyster pink), and is available in Lloydspharmacy and independent pharmacies.

Price: £3.99
Coty, tel: 020 8971 1300

Inbrief

Cardiomax

Seven Seas has clarified that Höfels Cardiomax may help maintain a healthy heart and circulation and is not a remedy for coughs and colds. The company issued the statement following its submission of an image of the product for *C&D's Winter Remedies* supplement (October 22).

Gut instinct

Raising awareness of the signs and symptoms of bowel cancer could make a significant contribution to early detection and cure, reports Sarah Purcell

Bowel cancer is the second biggest cause of cancer deaths in the UK after lung cancer, with 16,000 people dying from it every year and some 30,000 new cases detected a year. It's our third commonest cancer and around one in 20 of us can expect to get it at some point in our life. The good news is that if caught early 90 per cent of sufferers will survive.

The condition affects mostly older people, with 90 per cent of cases among the over 50s, though it's possible to get it much younger.

The rate of bowel cancer is increasing by 1 per cent a year. Partly because of this, and the fact that if caught early there's a good chance of survival, the Department of Health is introducing the first phase of a national bowel cancer screening programme in April 2006, the first of its kind in Europe. Professor Alex Markham, chief executive of Cancer Research UK, commented on the new screening programme: "Cancer Research UK is delighted about the Government's plans to introduce a bowel screening programme. Detecting bowel cancer early is vital and could save more than 1,000 lives a year. Catching cancer before symptoms become obvious means treatment can start promptly and more bowel cancer patients will be cured."

What will bowel cancer screening involve?

The DoH is investing £37.5 million in the programme in the first two years and it's the first cancer screening test for men and women in the UK. People aged 60 to 69 will be invited to take part in screening, with around 25 per cent of England covered by the end of 2006-07. A further 25 per cent of people will be offered screening from 2007-08 and the final 50 per cent from 2008-09. Those aged over 70 will be provided with a test on request.

The Scottish screening programme begins in 2007 and will be offered every two years to people aged 50 to 74.

Those eligible are sent a faecal occult blood test (FOB test) every two years, which is carried out at home and then sent back to the lab by post for testing. "Research has shown that screening men and women for bowel cancer using FOB testing can reduce the mortality rate from bowel cancer by 15 per

cent in those invited for screening," says Julietta Patnick, director of the NHS Cancer Screening Programmes.

The test is simple to carry out and involves scraping a small faeces sample onto a piece of card, which is then sent off. A chemical is then used at the lab to detect any signs of blood, which may indicate early signs of bowel cancer. Both patients and their GP will be sent the result of the test. "If you receive a positive test result you'll then be sent another FOB test to carry out. If the result of the second test is positive too a colonoscopy test would be arranged locally," says Julia Kennedy at Bowel Cancer UK (formerly Colon Cancer Concern). Around two out of every 100 people tested are likely to have a positive test result, but researchers only expect to find one or two bowel cancers for every 1,000 people screened.

A positive result doesn't necessarily mean bowel cancer – only about six out of every 100 people with a positive FOB test result will turn out to have it. The most likely cause of bleeding is haemorrhoids.

It's also important to remember that a negative screening result doesn't rule out bowel cancer either – if a growth isn't bleeding at the time the test is carried out there will be a negative result. This is why it's essential that anyone with possible bowel cancer symptoms gets referred for further investigation.

The DoH is also looking into using the flexible sigmoidoscopy test as part of the national screening programme. A sigmoidoscope is used to examine the rectum and lower bowel and remove any polyps found, before they can become cancerous. It's thought that this test may help protect against bowel cancer for the following 10 years, since this is believed to be the time it takes a polyp to become cancerous. Large scale pilot studies are to take place from April 2006 among men and women in their 50s and final results are expected back in 2007.

Will screening really help?

The FOB test hopes to prevent around 2,000 deaths a year by screening for bowel cancer, but it's also important because it will raise awareness of the condition and make it less embarrassing for people to discuss. As with any screening programme it isn't perfect – out of every 1,000 people who receive a normal test result less than one will be diagnosed with bowel cancer in the next two years. This is because not all cancers bleed – hence the importance of raising awareness of the signs of bowel cancer among the public.

There are a number of FOB screening tests that customers can buy, but is this something pharmacists should encourage? The same issue of false positive and false negative results applies to these as to the NHS tests, but with an OTC test customers won't have guaranteed follow-up.

"We would advise anyone considering having a test to speak to their GP first anyway," says Julia Kennedy.

What about screening for younger people? Younger people who are thought to be at higher risk of developing bowel cancer may be offered regular screening. Conditions which increase the risk of bowel cancer include an inflammatory bowel disease such as Crohn's or ulcerative colitis. Around 5-10 per cent of those who get it have a family history of the condition, and in this case it usually appears before the age of 45. These people will be referred to a family cancer unit for assessment and possible screening.

Raising awareness of bowel cancer

Some seven out of 10 people can't name a single symptom of bowel cancer, so raising awareness is crucial. "People in general are not as aware as they should be. This is a disease that lacks profile and is a subject that people find difficult to speak openly about. And few people know that when diagnosed early bowel cancer is highly treatable," says Ms Kennedy.

The pharmacy is often the first port of call for digestive disorders, so pharmacists are well placed to help raise awareness of the signs to look out for and refer patients to their GP if there is any suspicious symptom.

Signs to look out for include:

- Blood or mucus in the stools.
- Lasting change of normal bowel habits (ie diarrhoea or constipation).
- Losing weight.
- Pain in the abdomen or rectum.
- Straining feeling in the rectum.
- A lump in the tummy.

The DoH will be raising awareness of bowel cancer to encourage people to have the screening tests by posters in GP practices, leaflets sent out with the testing kits and national media coverage.

Reducing the risk

Exercise. Studies have shown that the risk of bowel cancer may be reduced by as much as 50 per cent in people who exercise regularly. This doesn't have to be sport – walking, gardening and physical activity all help. It's thought to affect hormone levels and the metabolic rate, helping the bowel to get rid of waste more quickly.

Eat plenty of fibre. Insoluble fibre (wheat bran, whole grains) is believed to deactivate intestinal toxins and help decrease the risk of bowel cancer. Soluble fibre (fruit and vegetables, beans and pulses) forms a thick gel in the stomach which feeds the intestinal bacteria and nourishes the cells of the large intestine, thought to reduce the development of cancer.

Lose excess weight. Being obese increases the risk of developing bowel cancer.

Eat less saturated fat. A diet high in fat and red meat and low in fibre is thought to increase the risk.

Calcium may be protective. Several studies have found that increasing calcium intake is linked with a lower risk of bowel cancer.

Where to find more information

Bowel Cancer UK advisory service, tel: 08708 50 60 50.

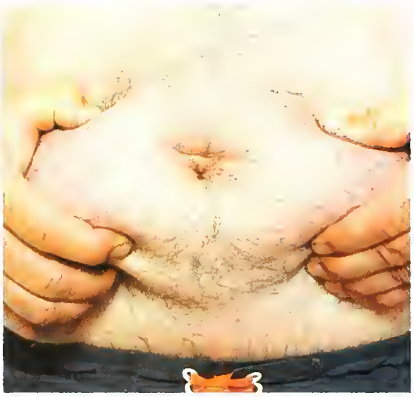
Beating Bowel Cancer, tel: 020 8892 1331."Don't Sit on your Symptoms" leaflets are available in packs, free of charge, by calling 020 8892 5256 or e-mailing *info@beatingbowelcancer.org.*

IBS focus

Irritable bowel syndrome is the UK's commonest digestive disorder, with 13 per cent of us affected at some time and it's thought that 10 per cent of GP consultations and half of all referrals to gastrointestinal clinics are due to IBS symptoms.

However, we still don't fully understand the causes of IBS and doctors differ on how they treat the condition. Many patients become disillusioned with conventional treatments and it's thought that 70 per cent don't seek medical help.

Probiotics have been the focus of much research in recent years for the treatment and prevention of irritable bowel conditions such as IBS. But in the last couple of years a number of studies have turned their attention towards prebiotics, which are believed to increase the amounts of bifidobacteria in the gut, improving the mucosal flora.



Glenn Chapman, professor of food microbiology at the university of Reading, comments: "There hasn't been as much research yet into prebiotics as there has been into probiotics, but what we've seen so far does suggest they'll work at least as well on IBS symptoms, and possibly give more enhanced changes to the gut flora."

Research has been carried out into its use on patients with ulcerative colitis and Crohn's disease too. A study published in the journal *Gut* found that inflammation was significantly reduced in patients with ulcerative colitis after treating with prebiotics.

"Prebiotics can also be taken for their protective effect on gut health. And because they're naturally occurring ingredients they have no harmful side effects and are safe for anyone to take. Around 5g-8g a day is recommended, though this does depend on the number of bifidobacteria there are in the gut to begin with," says Professor Chapman.

An increasing number of us are suffering from digestive disorders, with a third of respondents to a TGI survey admitting to indigestion and heartburn over the past year. And over the festive season some 20 million of us are likely to suffer with indigestion thanks to overindulgence.

But Christmas food and drink is only part of the reason why more of us are reaching for indigestion remedies. An ageing population, more of us eating and drinking out on a regular basis and many more foreign holidays all contribute to increased GI problems.

According to Mintel the indigestion market grew by 20 per cent from 1999 to 2003 and reached £237m last year. Indigestion remedies account for around half of all sales in this sector.

Rushed lunch leads to digestive problems

Research carried out by Rennie into the dwindling British lunch hour has found that one in four of us feel pressured into skipping our lunch hour to make a good impression on the boss, with those aged 25 to 34 least likely to take an hour off. Some 47 per cent of us grab a sandwich at our desks to save time. And while 20 per cent of healthcare workers say that a full hour off at lunch is vital to their performance in the afternoon, they take the shortest lunch breaks of all with one in five having just 15 minutes to eat.

The survey found that our short lunch break is often to blame for indigestion – four million are thought to suffer heartburn after a rushed lunch.

Bayer is supporting its new Rennie brand with a £5 million advertising campaign and new point of sale merchandising units. The range includes Original Rennie, Rennie Soft Chews, Rennie Sugar Free, Rennie Rap-Eze and Rennie Liquid Relief.
Bayer Consumer Care, tel: 01635 563000

Bisodol Indigestion Relief tablets are being supported by a £1 million spend which includes television and press advertising as well as posters and PR activity.

Forest Laboratories recently acquired the brand and product manager Julie Sutherland comments: "The Bisodol brand has a strong herigage and an extremely loyal customer base. We are confident that following our acquisition of the brand, this year's marketing campaign will drive sales and increase the brand's market share."

Forest Laboratories, tel: 01322 550550

GI product news

Research by the maker of Pepcidtwo has found that 83 per cent of heartburn sufferers are distracted by the pain it causes and 66 per cent said it impacted on their quality of life. Pepcidtwo combines an antacid with an acid balancer.

It starts to neutralise stomach acid within two minutes and keeps symptoms at bay for up to 12 hours.

McNeil,
tel: 0800 032 8258

Setlers Antacid tablets and WindSetlers Gel Caps are being supported by a £1 million advertising campaign that will run until next spring.

The advertisements will feature on GMTV and Channel 5. The aim of the campaign is to continue building awareness of Setlers for relief of acid indigestion, heartburn and flatulence.

Thornton & Ross,
tel: 01484 848200

Around 10 per cent of the population suffers from constipation on a regular basis, with one in three women and one in five men admitting to it, says the maker of Califig.

The laxatives market is currently worth £51.6 million and growing by almost 8 per cent a year. Califig with senna is a natural fruit-based liquid laxative suitable for adults and children from one year old.

Merck Consumer,
tel: 01482 375234

Artichoke leaf extract is thought to help the liver and gall bladder digest fat and metabolise alcohol more efficiently. A recent study in the *International Journal of Phytotherapy and Phytopharmacology* found that artichoke promoted bile production in the liver by 127 per cent. Cynara Artichoke supplement is recommended for indigestion and overindulgence.

Lichtwer Pharma,
tel: 01628 487780

One in three people suffer haemarrhoids at some time, yet 22 per cent of those who get them don't treat the condition because they're too embarrassed to ask for help. Haemorrhoid treatment Germoloids is being supported by a £1.5 million TV campaign that runs until the end of the year. The newest product in the range is Germoloids Soothing Wipes, designed to be used alongside treatment as an alternative to toilet tissue.

Bayer Consumer,
tel: 01635 563000

Reckitt Benckiser is supporting its new Gaviscon Cool Handy Pack with new television advertising which runs until Christmas. There are three new advertisements in the campaign.

Reckitt Benckiser,
tel: 01793 732000

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Creation d'Shi is looking to build a small team of sales specialists to cover the UK's main retail areas in time for an intensive TV advertising campaign planned for next February.

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If you have some perfumery or related sales experience and would like to be part of this new brand, please send us your C.V. and contact details. We will provide more product information and details about interviews and time scales.

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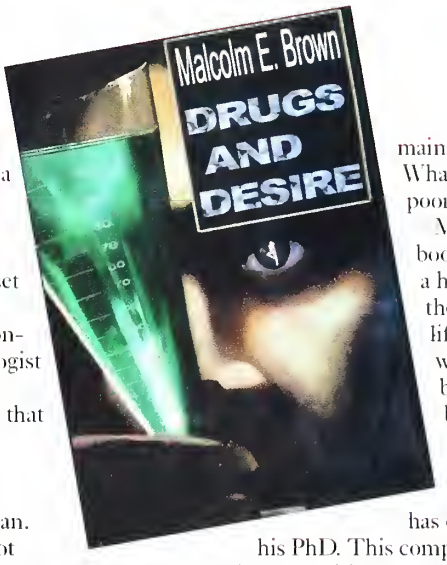
Who got the **duchess** pregnant?



See, the headline got you interested. But what has it to do with possibly the first novel to have a pharmacist as the hero? You'll have to read the "slightly racy" book and see.

Drugs and Desire features a man who is described as "a decent ordinary bloke. He is beset by problems, an underdog with guts." Sound familiar? As for the villain, he "is a golden-spoon-in-the-mouth womanising rogue. He is a sociologist with spivvy charm."

The book is temptingly described as "a novel that sizzles" and a modern morality tale with good triumphing over evil. "Passions simmer and explode." In summary, the pharmacist and the sociologist meet and fight for the love of a woman.

Perhaps it's not surprising, then, that the author, Malcolm Brown, left, just happens to be qualified in both of these professions. He believes that there is no other novel with a pharmacist as hero and which attempts to put a pharmacist as hero into popular mainstream culture. What about those poor sociologists?

Malcolm says the book took one and a half years ("and the best part of a lifetime") to write. He has been published before, but normally for his sociological research which has centred around his PhD. This comprised the first 'ethnography' about British community pharmacy.

As for the reference to the duchess, Malcolm refers to the statement: "My God," said the Duchess, "I'm pregnant. Who did it?" He hopes that if sufficient heat and critical mass is generated for the novel to be picked up by the mainstream media, "it might just do a lot of good for the public image of pharmacists".

The book is out now. *Drugs and Desire* is published by Exposure Publishing, Three Rivers, Minions, Liskeard, Cornwall. ISBN 1905363672. 250pp. Price £9.99, and is listed on *www.amazon.com*.

I'm too **dusty** for **my cat**

Cats and other mammals of a furry persuasion are often the first to get the blame for causing asthma in humans, but did you know that humans can cause asthma in cats?

According to researchers from the University of Edinburgh's Hospital for Small Animals, cigarette smoke, dusty houses, human dandruff or pollen can all inflame poor Tiddles' airways and worsen his asthma.

The Edinburgh team believes that as many as one in 200 cats suffer from the condition and are currently recruiting 50 cats to take part in a study investigating the link between infection with bacterial mycoplasma and the disease.

Cats are known for their inscrutable stare. Now you know what they are thinking.

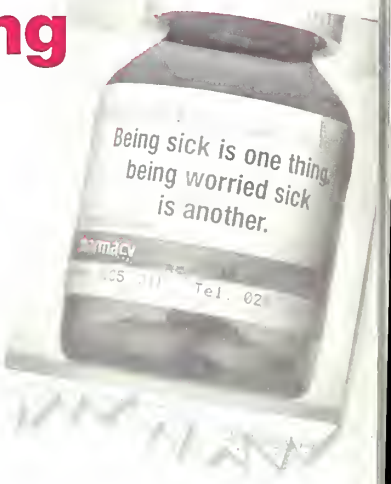
Co-op takes up the **charities' challenge**

There must be something in the water at the Co-op. Not content with running busy pharmacies, Co-op staff have been running, walking and cycling for charity.

A team of 23 runners took to the streets of Cardiff recently to run a half marathon in aid of the Prince's Trust's Go Red for Wales campaign, raising £4,000 in the process, while another team visited every one of the company's 350 branches in a relay tour involving foot, bike, car and boat power. The aim is to raise money for Shelter's Million Children campaign.

Ready for the off are, from the left: Co-op head of commercial Peter Roche, store design and development manager Rachel Webdale, acquisitions and business development manager Peter Willis and general manager Neil Braithwaite

A case of **postcode prescribing**



"Being sick is one thing, being worried sick is another," says the advert promoting private healthcare which has been gracing the newspapers recently. "Sometimes the anxiety of what may be wrong with you can make you feel worse that the condition itself."

But how anxious would you be if you received a bottle labelled fusidic acid 2 per cent and hydrocortisone 1 per cent and it contained tablets? What could you have? Eczema of the throat? A fungating stomach ulcer? Perhaps a reaction to eating toadstools?

Unfortunately, the pharmacy which generated the label can't be asked what the doctor's prescribing intentions were. With a non-existent London postcode of WC5, it would seem the pharmacy operates in a very special locality.

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